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EDITORIAL

Faking It

Last night I (MP) watched the first in a new series of Channel Four's 'Faking it'. In the programme a young cycle courier from Manchester, much pierced and tattooed, spent four weeks learning how to fake being an experienced polo player. At the beginning he had never sat on a horse before and showed a remarkable lack of hand-eye co-ordination. During the intensive training he got drunk when he should have been preparing for an important match, swore mercilessly at his long-suffering mount, and seemed to lack the necessary competitive spirit. Yet, at the end, and very much against the odds, he was able to fool three 'expert' judges that he had been riding for years and was an experienced polo player.

As a sociologist and a rider, the programme got me thinking. On the one hand, what an amazing achievement and how come I've been riding all my life and would not have been able to pull that off? On the other hand, how must the other competitors have felt when the judges thought they were the ones who had only been riding for a month when in fact they had about 15 years riding and many seasons of polo between them? How must the 'expert' judges have felt when told that they could not tell an experienced polo player from a beginner? Were they offered counselling to cope with their injured pride? As sociologists we have to go through enormous hoops, wonderfully described by Stella Silvester and Judith Green in the last issue of MSN, to ask people the most innocuous questions. In my part of the world if there is any possibility of respondents being upset, we have routinely to offer them counselling, although the value of counselling is now being questioned. Do TV companies have to go through ethics committees before they produce these programmes and, in the case of much so called 'reality TV', publicly humiliate people? Do participants sign written consent forms and have the right to withdraw any time it gets uncomfortable for them?

Another point about the programme was that it revealed, in the most unsubtle and cringingly embarrassing way, the persistence of class differences in modern, Blairite Britain. The polo playing and watching set are a race apart, with their own language, clothes and culture. It was amazing that a lad with tattooed arms and a northern accent almost managed to pass as one of them at a £100 per head lunch in a marquee. Is this another example of TV doing more interesting work than us, as Raymond DeVries highlighted in the last issue of MSN? Let us know what you think.

Chris Yuill has taken up the challenge laid down by Raymond DeVries in one of our four articles this issue and calls for us to be more radical and proactive in our approach to the world we study. Mark Ebert, coming from medical anthropology, also gets us thinking about the limits of medical sociology. The Phil Strong prize winner Helen Leibling has written a deeply disturbing essay about the mental and physical suffering of women in one war torn African country, which also provides for provocative reading. Fittingly, we include it in this issue as well as a review of an art exhibition on pain which Hannah Bradby and her students visited recently. In addition we have the usual crop of book reviews, PhD abstracts, conference reports, including some further feedback on last year's conference in York, and problems to be addressed by our long-suffering agony aunt Marge.

We would also like to announce that MSN will be accepting adverts for academic books and courses from publishers and higher education institutions. Please encourage anyone you know with a course or book to promote to get in touch with us.

Professor Meg Stacey

We were very sorry to learn of the death of Professor Margaret Stacey on February 10th 2004. She was a pioneer, whose contribution to Medical Sociology was enormous, and her influence was by no means limited to our field. To quote from a book review a few years ago in the *British Medical Journal:*

> Meg Stacey, emeritus professor of sociology at the University of Warwick, recently commented with characteristic honesty that much of the early sociological research on childbirth was performed by people who wanted to make things better for people like themselves. They were unwittingly colluding in a failure to recognise how we make invisible the experiences, beliefs, and practices of "others". This "blindness", which academia and medicine have shared along with other British institutions, provides fertile ground for racism and impoverishes us all, both personally and professionally.[1]

We include an obituary by Virginia Oleson in this edition and will have one by Anne Murcott in the next. The summer edition we plan to give over to a celebration of Meg's life and work, with the support of Gillian Bendelow. Please send all contributions in the normal way.

An Apology

We are sorry for the inconvenience caused by omitting to put the payee on our last reminder re subscriptions and as a result have had to return a lot of cheques. Please bear with us during this time when we are without our admin assistant Liz Grant. We wish Liz all the best and hope that she makes a speedy recovery from her illness.

Maureen Porter
Edwin van Teijlingen
Chris Yuill
Karen Forrest
Lydia Lewis
Fiona French

Reference:

1. Kathryn Ehrich (2000) book review 'Race' and Childbirth by Savita Katbamna Open University Press, £18.99, pp 144, *BMJ* 2000; 321:1418.

Please send copy for the August edition of MSN to the editors by: 30th June 2004

NEWS AND NOTICES

About the British Sociological Association

The British Sociological Association (BSA) is the professional association for sociology in Britain. The Association was founded in 1951, and our members are drawn from a wide range of backgrounds - research, teaching, students and practitioners in many fields. The BSA provides services to all who are concerned with the promotion and use of sociology and sociological research.

Membership Benefits

- Membership includes subscription to one of the BSA internationally renowned journals - Sociology,or Work, Employment & Society
- Members are eligible to subscribe to the second journal at 50% discount (£29.00)
- Three issues of our informative newsletter Network, published Spring, Summer and Autumn
- 30% discount on all SAGE Publications including books and journals
- 50% discount on selected SAGE Publications journals
- Support Fund - awards to a maximum of £150 per applicant are awarded. New members are eligible to apply. No submission deadlines, applications are considered throughout the year, as and when received. Awards are considered for: conference/event attendance (BSA and non-BSA events); thesis binding; research & fieldwork expenses
- 75% discount on full conference registration to attend the BSA Annual Conference, inclusive of accommodation, breakfast and lunches.
- Free annual conference registration is available to 50 student members. Awarded on a first-come, first-served basis.
- Free membership to over 25 specialised study groups, such as: consumption; emotion; food; gender & ethnicity; religion; news media; Weber; youth; education, plus many others. Joining one or more of these groups will greatly enhance your knowledge on a particular topic.
- Postgraduate Summer School. Funded by the ESRC, this FREE event is open to 35 full/part-time students each year. All travel expenses are reimbursed. The next event will take place in September 2004 at the University of Southampton.
- Postgraduate Forum. Join the PGF and receive regular emails about forthcoming events and news items, and share common interests and problems.
- Apply for the Philip Abrams Memorial Prize (£1,000), as well as the Phil Strong Memorial Prize (£500)
- Reduced conference fees to events organised by The Australian & American Sociological Associations, The Canadian Sociology & Anthropological Association, and the Social Policy Association.
- Access to the Members' Area of the BSA website: www.britsoc.co.uk
- Members' Area. A membership number is required to access this area. It includes: A searchable database for both journals. Members have exclusive access to full-text electronic versions of issues prior to 1998.
  - Current version of Network
  - Sociology Jobs/Vacancies
  - Sociology Courses
  - Sociology funding/grant opportunities
  - Online discussion forum
  - CV Noticeboard - a forum for members to advertise their CV's to prospective employers

For a full listing of membership benefits and subscription rates, visit the appropriate link on the BSA website at: www.britsoc.co.uk/membership or contact the BSA Office on 0191-383-0839.

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Web site: www.britsoc.co.uk

Maney is pleased to announce the launch of a new journal

CHRONIC ILLNESS

Maney Publishing is launching a new international journal to focus on the clinical and theoretical challenges posed by chronic illness

Editorial Team

Chronic Illness will be edited by Christopher Dowrick, Professor of Primary Medical Care at the University of Liverpool, UK. He is joined by three Co-editors: Mary Dixon-Woods, Department of Health Sciences, University of Leicester, UK; Halsted Holman, Division of Immunology and Rheumatology, Stanford University School of Medicine, USA; John Weinman, Department of Psychology, King's College London, UK; and an international advisory board. Board members have been drawn from expert patient groups and from key academic and clinical disciplines.

Readership

Chronic Illness will be an important journal for those who study, work with, manage or experience chronic illness.

Call for Papers

For the submission of articles, please write to Professor Christopher Dowrick, Department of Primary Care, University of Liverpool, Liverpool L69 3GB, UK
E-mail: cfd@liverpool.ac.uk

Aims and Scope

Chronic Illness will integrate academic, clinical and patient perspectives and promote new thinking about models of illness and care. It will consider the range of appropriate clinical and psychosocial interventions, including organizational frameworks at the interface between primary and secondary care. The journal will encourage the study of:

- emerging issues in early diagnostics
- outcome based performance, data gathering and surveillance challenges
- ageing and developmental issues
- the changing self-perceptions of people with chronic illness
- quality of life measures and interventions
- medication concordance
- and the efficacy of self-management strategies, group participation programmes, and remote medical management.

Context

The management of chronic illness is beginning to develop its own identity as an important component of health care. No longer is each chronic illness being considered in isolation. Awareness is increasing that similar strategies can be effective in treating many different conditions. These are likely to involve the proactive identification of relevant populations; to provide support for the relationship between people living with long term health conditions and health and social care professionals; to develop evidence-based care guidelines which emphasise the prevention of exacerbation and complications; and promote patient empowerment strategies, such as self-management and education. They also require continuous evaluation of clinical, humanistic and economic outcomes.

The title Chronic Illness is chosen to highlight our interest not only in the biomedical manifestations and management of these long-standing conditions, but also their psychosocial contexts, and the experiences of those who live with them.

Pricing

Chronic Illness, Volume 1, 2005 (first issue due autumn 2004) 4 issues per year (online and print)

Institutional rate: £138.00 North America: US$198.00
Individual rate: £48.00 North America: US$78.00

Special introductory discount for individual subscriptions placed before the end of 2004: £38.00 / US$62.00

Further Information

If you would like to receive further information on Chronic Illness as it becomes available, please e-mail: charis_boutieri@materials.org.uk
For further details or to subscribe online please visit:
www.maney.co.uk/journals/chronicillness

Sociology of Health and Illness: Reviewers Needed

The editorial team of Sociology of Health and Illness invite volunteers to join their list of manuscript reviewers. The success of the journal, and the popularity of the new online submission and review process, mean that we are on course to double the volume of papers needing review. Those papers are also coming from increasingly diverse scholarly and national backgrounds. In order to alleviate the burden on our existing reviewers, and to produce as fast a turn around as we can manage, we would like to invite new volunteers. While we will continue to be a journal that welcomes qualitative and theoretical work, we would at this time particularly like to encourage volunteers who can strengthen our list in the area of quantitative work, particularly survey methods. These papers have formed an increasing proportion of the rising number of submissions, and we are concerned to ensure that they receive fair and appropriate review.

If you interested in helping, then enter your name into our referee database:
Go to http://shi.manuscriptcentral.com/
1. Select 'Create a new account'.
2. Supply full contact details, including key words.
3. Specify password (note, this is case sensitive) - please keep a copy for information.
If you experience any difficulties creating a referee account, contact Allison Pearson at Email: Allison.Pearson@nottingham.ac.uk for assistance.

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Professor of Sociology
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web page http://www.nottingham.ac.uk/igbis

ALCS - What's That?

Many Medical Sociology Group members may not be aware of the Authors' Licensing and Copying Society (ALCS). This is the UK rights management society for all writers - even academic ones. Its principal business is to collect and distribute fees to authors whose works have been copied, broadcast or recorded. It also collects monies for lending and rental. Since its foundation in 1977, ALCS has paid writers over £79 million in fees - fees they would not have been able to collect individually. It also acts as a lobbying group on behalf of authors' rights, both in the UK and in the EU. ALCS is wholly owned and controlled by its members.

Apart from the benefits of representation at a time when there are many pressures on authors' rights in their work, membership brings direct cash benefits. ALCS administers payments from the Copyright Licensing Agency (CLA). Whenever a copyright work is copied, a fee must be

paid to the CLA. This is passed on to ALCS who then transmit it to the author in a distribution that takes place twice a year. In some cases, large users pay a global fee, which is then distributed proportionately. From 2003, the NHS has been participating in a scheme of this kind: about £1/2 million has been received by ALCS and is being distributed among those members who have authored books or published in journals directed at health care and medical readers. This includes areas like medical sociology, health economics and health services research.

When I have mentioned the benefits of membership to colleagues in the past, some people have been disinclined to join on the grounds that their fee income is diverting resources from the main business of organizations like the NHS or universities. This is certainly an argument, although in both cases, the money is ring-fenced and not available for other uses: self-denial simply leaves a bigger share for others! The sums are not large in our business. Nevertheless, the tax-deductible, £10 annual membership fee and the 11 per cent royalty are easily covered and the public-spirited can always donate the income to their favourite good cause. There is also the value of the reports. In an age of performance indicators, I have occasionally found it very useful to point to the number of times that my work has been copied, at least by those bodies that participate in the scheme by returning details of actual or sampled usage. Finally, the value of lobbying to ensure proper recognition of the interests of authors looks likely to be increasingly important in the face of the emergence of new media and the challenges to established rights in intellectual property that are coming with them.

Further information can be found at www.alcs.co.uk

Robert Dingwall IGBiS,
University of Nottingham

Co-Convenorship of MedSoc Group

This year for the first time the BSA Medical Sociology Group has two co-convenors: Davina Allen and Catherine Exley, replacing Hannah Bradby, who completed her three years as convenor at the 2003 conference. We would like to take this opportunity to introduce ourselves and to explain the rationale for the introduction of the co-convenorship.

Davina is Director of the Nursing, Health and Social Care Research Centre in Cardiff, and Cath is Lecturer in Medical Sociology in the Centre for Health Services Research, University of Newcastle. Both of us, like all previous convenors, have been committee members for four years and have been involved in the wide range of activities carried out by the committee in order to ensure the annual conference runs smoothly.

There are two reasons for the change to a co-convenorship. Firstly, historically there has always been a Convenor and Treasurer who worked closely together. However, with the Group's finances being incorporated into the BSA finances in 2001, the need for someone on the committee devoted to finance disappeared. Secondly, when Hannah's 'term of office' was coming to an end and the committee discussed who might succeed her, there were few volunteers. In today's academic world few of us feel able to commit the time and effort needed to convene the Group. It is a reflection of Hannah's dedication and organisational skills that she managed to perform this extra role so efficiently single-handedly. Having worked together on the Committee for the

last four years, we both felt reluctant to take on the 'job' individually, but we were prepared to do it as a team. We are in the early stages of sorting out a precise division of labour, but we hope that working in this way will be beneficial, both to the Committee and the wider group, as well as ourselves. A co-convenorship is something we both wanted to do, but it does not set a precedent for future convenors who may be willing to take on this role individually.

We are grateful to Hannah for all her hard work over the last three years, and are very aware that we have a hard act to follow! We look forward to working with the new committee and the wider group over the next three years. We can be contacted via the MedSoc website at: Medsoc.convenor@britsoc.org.uk

Davina Allen and Cath Exley
Co-convenors BSA Medical Sociology Group

Obituary: Professor Margaret Stacey (1922-2004)

Margaret (Meg) Stacey, Professor Emerita of Sociology, University of Warwick, influential medical sociologist, unceasing advocate for the rights of women and the welfare of children and lifelong champion of human rights and peace, died on Tuesday February 10th after a struggle with congestive heart failure. She was 81.

Her long and distinguished career included faculty positions at University College, Swansea and the University of Warwick, where she chaired the Sociology Department (l974-1979), the Graduate School of Interdisciplinary Studies (l985-1989) and the Management Committee of the Nursing Policy Studies Centre (1985-1989) which she had established. She held numerous visiting professorships and lectureships in California, Ohio, South Africa, Iceland, Central America, Finland, Canada and Australia.

Other honours came her way: she was elected president of the British Sociological Association in l98l. In l987 she was made an Honorary Fellow of the University of Wales, Swansea. Keele University gave her the honorary Doctor of Laws degree in 1989. The University of Warwick opened its Centre for Health and Society in 1999 with an international conference honouring her, and her work. On that occasion she noted the theme of her life's work: "The question of suffering has underpinned much of the work I tried to do over the years, particularly the suffering which we human beings inflict on one another, individually or collectively."

Although she had done early work on community studies with a classic study of Banbury and a later follow-up, her most notable achievements were in the sociology of health and illness/ medical sociology, a field which she helped pioneer and shape. She was a key figure in the establishment of the British Sociological Association's Medical Sociology Group.

Her empirical work on children in hospital, the division of labour in health care, regulating British medicine, her conceptual writing on constructions of health and illness, medical accountability and ethics, and recent writing on genetics and assisted reproduction, generated significant works which other non-medical sociologists and policy makers read. Talented students, attracted by these writings and her substantial reputation as a generous mentor and teacher, flocked to take degrees with her and go on to their own productive careers.

However, Meg Stacey was no "arm chair sociologist." Passionately devoted to enhancing the public good, she was an indefatigable participant on innumerable regional and local boards of organizations concerned with women's and children's well being, and at the national level served eight years (1976-1984) on the General Medical Council which regulates British medicine. A vigorous feminist she was at the forefront of numerous struggles around women's issues. Her feminism also suffused her writing. The book (with Marion Price) on women, power and politics won the Fawcett Prize. Her challenge to accepted conceptualisations of the public/private divide and the division of labour took feminist thinking in new directions. In 1999 she went to Montenegro, Republic of Yugoslavia to confer and work for peace with Women in Black.

Meg Stacey was born 27 March 1922 in London, where she was educated at the City of London School for Girls. In 1943 she took the B.Sc.(Econ) with First Class Honors at the London School of Economics. In 1944 she served as Labour Officer in the Royal Ordnance Factory. After marrying Frank Stacey, a political scientist, in 1945 while he was on leave from military service in Germany, she was a tutor at Oxford until 195l. In 1951 she followed Frank to Swansea, where Frank had a post in the Politics Department of University College, Swansea (now called University of Wales). She was "unwaged, but not unemployed, being busy rearing children and writing Tradition and Change", as two interviewers described it later. She got a job in 1961 in the Swansea Sociology Department, where she advanced to Senior Lecturer in 1970 and was seconded in 1972 as Director of the Medical Sociology Research Centre.

In l974 they moved to the Midlands where she joined the University of Warwick faculty and Frank, the University of Nottingham faculty. (Frank Stacey died in 1977, leaving an important book on ombudsmen, which she completed). She retired from the University of Warwick in 1989.

Her companion, Jennifer Lorch of Leamington Spa; her sister, Elizabeth Sells of Bath; five children, Patricia Baldwin, Richard Stacey, Kate Sarson, Peter Stacey, Michael Stacey, sixteen grandchildren and one great grandchild survive her.

Although she took pleasure in her professional accomplishments, Meg also thoroughly enjoyed her large family and circle of colleagues and students, many of whom became close friends. Witty and fun loving, she set many a gracious dinner table for family and friends. Among other memorable recollections were conferences where music for dancing would bring Meg and her friends to the floor, joyfully enlivening the occasion.

Services were held on February 19th at Catthorpe Manor in Leicestershire and burial was at Greenhaven Woodland Burial Ground, New Clark's Farm, Warwickshire.

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FORTHCOMING EVENTS

The British Sociological Association

MEDICAL SOCIOLOGY GROUP

Annual Conference 2004

September 16th - 18th University of York

Plenary Speakers will be

Peter Conrad

Harry Coplan Professor of Social Sciences Brandeis University

who will speak on:

'The Shifting Engines of Medicalization'

Judith Green

Senior Lecturer in Sociology London School of Hygiene and Tropical Medicine

who will speak on:

'Professions and Community'

Further details and abstract submission form available from: bsamedsoc@britsoc.org.uk and www.britsoc.co.uk/msconf

The abstract submission deadline is April 23rd 2004

Abstracts received after this date will not be considered

BSA London Medical Sociology Group

Venue: King's College London, Room 1.16,
Franklin Wilkins Building, Stamford Street, London SE1 8WA

Nearest tube and rail: Waterloo

MEETINGS 6PM - 7PM

Everyone is welcome to attend LMSG meetings. The group has no formal membership. At each meeting there is a presentation by a speaker, followed by discussion that continues over drinks and supper in the local pub.

14th April	**How do men become and remain involved in bodybuilding?**	**Kim Clarke** King's College London
12th May	**Ageing as a community of interest: consequences and contradictions**	**Paul Higgs** University College London
9th June	**The lottery of complementary medicine: making decisions about treatment for chronic fatigue syndrome**	**Susan Robinson** King's College London

For further copies of this programme please contact Paul Godin 020 7040 5933. To receive details of all LMSG meetings by e-mail contact **Mark Newman, m.newman@ioe.ac.uk** or visit the **BSA website: britsoc.co.uk/** Joint LMSG Organisers: Richard Compton, Jacqueline Davies, Paul Godin (Convenor), Miranda Leontowitsch, Mark Newman (Mailing), Susan Robinson (Treasurer) & Steven Wainwright.

North East and Midlands Sociology of Health and Illness Group

Call for seminar papers

Venue: Sheffield Hallam University, Room 7131, Stoddart Building, City Campus
Date and time: 19th May 2004, 10.30am-4.00pm

This study group, which is affiliated to the British Sociological Association, provides an informal and supportive venue for discussion of work in progress or early research/ publication ideas. We particularly welcome research students and those new to the field of the sociology and health and illness.

We have arranged a full day meeting (with lunch!) and now need some offers from people willing to present their work. There is no charge for this meeting, and we may be able to help with students' travel expenses. Please let **Jane Seymour** know if you are interested in either presenting a paper or want to attend the meeting,
E-mail: **j.e.seymour@sheffield ac.uk**

West Midlands Medical Sociology Group
Social Aspects of Health, Illness and Medicine: Postgraduate Event
Venue: University of Warwick May 19th and 26th 2004

Are you...
New to research?
Nearly/just finished your PhD study?
Looking for somewhere friendly to present your results?
In the midlands area?

If so, please come to the University of Warwick on 19th and 26th May 2004 when two half-days of research presentations on social aspects of health, illness and medicine with informal, constructive questions and feedback are planned. The meetings will include lunch and tea and are co-sponsored by the British Sociological Association Medical Sociology West Midlands Group and the Forum for Health, Medicine and Society and the Institute of Health at the University of Warwick. The presentations will be chaired by Hannah Bradby and Alan Dolan.

There is no charge to attend this meeting and limited funds are available to pay travel expenses for students.

The number of places is limited and they will be allocated on a first come, first served basis.

If you wish to attend, please send a 100 word outline of your 15 minute presentation to: **Cecilia.Olivet@warwick.ac.uk**

Scottish BSA Medical Sociology Group

A meeting is planned for the afternoon of **Friday 4th June** (to be confirmed) at the University of Glasgow as part of the series of sessions on the topic of **families, violence and health**.

Two presentations are scheduled:

Debbi Hindl	Defining and Understanding Emotional Abuse
Sarah Nelson	The Longterm Physical Health Effects of Violence Among Adult Survivors

We anticipate two further meetings in 2004. In the autumn we hope to hold a half day session on user involvement and later in the year another session in the on-going programme of workshops on ethics.

For further information please contact:
Linda McKie (l.mckie@gcal.ac.uk) or
Gill Hubbard (gh77c@clinmed.gla.ac.uk)

Sociology of Mental Health: a neglected area in Medical Sociology?

I was very pleased to see a number of papers from those working in the field of the sociology of mental health at last year's annual BSA MedSoc Conference. However, this still seems to be a very much neglected area within Medical Sociology and we would welcome submissions from anyone who is willing to cast light on why this may be! In addition, if there is anyone interested in setting up a Sociology of Mental Health Study Group within the Medical Sociology Group, I would be pleased to hear from you.

Lydia Lewis (E-mail: l.lewis@abdn.ac.uk)
University of Aberdeen

Cartoon by Mel Calman (c) S. & C.Calman.
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CONFERENCE REPORTS

Reflections and feedback on the BSA Medical Sociology Conference 2003

The 2003 conference saw a number of changes to previous years: self-streaming, uniform 30 minute slots for parallel papers, the James Kirk dining room (replacing the rather tired Goodricke Dining Room) and a conference dinner. After the conference the Group's co-convenors sent an email to all delegates requesting feedback. This article summarises briefly the committee's reflections and delegates' feedback.

The programme organisers felt that the self-streaming worked well, and there was generally positive feedback from delegates about the 30 minutes slots for papers, which allowed people to move more easily between different sessions. A small number of people felt the slots were not long enough to develop a detailed theoretical argument, but this was a minority view. We will continue to review this for this year's conference. We are also aware that some delegates expressed concerns about the quality and relevance of some papers. Clearly the quality of papers is a matter for presenters rather than the programme organisers, however, this year people submitting abstracts will be reminded of the need to illustrate the relevance of their paper to sociology of health and illness. Papers which do not demonstrate relevance, will be rejected.

It is with great delight (and relief!) that for the first time in many years the committee received positive feedback on the standard of catering. Overall the food was much improved on previous years. The conference dinner went particularly well, no doubt aided by generous quantities of wine! We hope that the support for this event will increase for the 2004 conference.

Getting people to chair sessions is always difficult, but the 2003 conference proved to be particularly challenging. In fact, direct intervention was needed as people registered, involving anything from gentle cajoling to outright bribery! The contribution of session Chairs is essential to the smooth running of the conference, and we urge colleagues when approached, to help us in this way. This year, anyone submitting an abstract who is not a new-comer or postgraduate, may be asked to chair a session.

The conference seeks to be as inclusive as possible, but regrettably, because we have to book venues years in advance, this is not always possible. As we are limited as to when York is available to us, it is not always possible to ensure that we do not clash at all with any of the world's religious festivals. The 2003 conference coincided with Jewish New Year and regrettably this is also the case for the 2004 conference. We apologise to all colleagues who are unable to attend the conference and will endeavour to avoid clashes in the future. However, York remains one of the few venues, relatively easily accessible by all, which can accommodate a conference of our size in one location.

We would like to thank the BSA office, in particular Nicola Gibson, and Neil James and his team at the York Conference Office who continue to work hard to ensure that as far as possible our annual conference runs smoothly.

Davina Allen and Cath Exley
Co-convenors BSA Medical Sociology Group

Feedback on the 2003 conference from students in receipt of bursaries

As a PhD student within the faculty of Health and Social Care, I was lucky enough to receive a free place to attend the Medical Sociology Conference in York, 26-28 September 2003. This is the first time I have attended this conference, yet after spending three very enlightening days in York, it hopefully will not be the last!

On arriving at the beautiful York University campus I was given plenty of information about all the presentations/posters/workshops/ plenary sessions on offer. The only problem I had when looking through the conference programme was trying to be discerning and pick a manageable number of presentations to attend. Other delegates could be heard to audibly mutter 'oh... I want to hear that as well....' Always the sign of a good conference when people (myself included) want to see and hear more than is physically possible!

Presentations were arranged into topic areas. This was useful when deciding which presentations to attend. I was particularly interested in the sessions that came under the headings of 'experiences of heath and illness', 'theory and ethics', 'methods' and also 'risk'. These topics were directly related to my PhD research, and I was keen to hear the experiences of other researchers in these areas.

Many of the presentations were thought provoking. I would leave these sessions scribbling down references furiously (it would have been very beneficial if presenters had prepared a handout with salient points/references or contact details). All the presenters that I spoke to were approachable and helpful, and more than willing to discuss their research with a novice researcher. This networking was such a useful aspect of the conference. It build's your confidence to talk to other like-minded professional researchers and academics, and it really does restore your faith in the pursuit of a PhD when you speak to other students. It highlights the fact that no PhD problem is unique!

Whilst all the presentations I attended were first class, I feel that the plenary session by Professor Raymond de Vries was excellent. He spoke about ensuring that medical sociology as a discipline remains true to its original principles. His talk was illuminating and inspiring. He engaged with the audience through the use of humour, though never diminishing the importance of the subject. As an orator, he was entertaining and informative, and I came away from that session determined to investigate some of his previous work, as I felt so inspired by his enthusiasm.

When not listening to presentations it was possible to browse among a number of exhibition stands selling books and journals from different publishers. This was ultimately tempting, and only tempered by the fact that no student discount was offered.

This was an enjoyable and challenging conference for me. It made me shift and re-focus my academic thinking from a previously purely psychological perspective to a more socially centred approach. I would not hesitate to recommend this conference to others and feel that I gained an awful lot from the experience. I am grateful to the British Sociological Association and the University of the West of England for giving me the opportunity to attend.

Karen L Shepherd PhD Student,
University of the West of England

As I am using sociological theory to underpin my PhD thesis, the opportunity to attend Med-Soc's annual conference was extremely valuable to me, particularly since I do not have a grounding in the discipline. I was impressed by the wide range of topics covered by the presentations offered over the weekend, as well as by the range of nationalities represented by delegates.

On scanning the programme, I discovered that I was able to indulge not only my research interests, namely inter-professional issues in the health service and reproductive health; but I was also able to attend presentations about or involving specific methodological and theoretical issues, which I found to be immensely helpful for my thinking about my own work, as well as very interesting in their own right. Additionally, there was the added bonus of hearing presentations of work whose topics were slightly different from those one normally comes across at conferences concerning health services research, for example, the paper offered by KD Clarke concerning her ethnographic study about bodybuilders. Another useful feature of the conference was the inclusion of workshops on selected topics, which enabled small groups of delegates with a particular interest to meet and network. I felt that offering such a comprehensive programme enabled me both to be educated and entertained, often simultaneously.

I was also struck by the range of experience on offer. It was clear that some presenters were very experienced, while others were just starting out in their academic careers. It was encouraging to see that there was a place for everyone, and that novice researchers were supported in presenting their work to an audience which, while it might be appropriately critical, never appeared to be hostile or dismissive.

I thought that the plenary speakers were excellent. I particularly enjoyed Raymond de Vries' refreshing perspective on the value of research and academic endeavour. The extensive display of journals and books in the exhibition centre afforded opportunities to browse happily, and I was pleased to be introduced to a number of useful and interesting journals of whose existence I had been previously unaware.

The organisation of the conference was admirable, with sessions invariably running to time. On occasion I wished that the session times had been a little longer, as there was sometimes the feeling that a presenter had much more of interest to offer, but was unable to do so because of time limitations. Finally, I wish to mention the high standard of the accommodation and catering, which put the finishing touches to a very well-organised and stimulating event.

I am grateful that I was able to attend the conference, I feel I gained considerably from my attendance there, and I look forward to attending future conferences, and hopefully to presenting my own work in this forum.

Katherine Pollard, PhD Student,
Faculty of Health and Social Care, University of the West of England, Bristol

An early Friday morning Ryanair flight from Dublin enabled me to browse through picturesque York in brilliant sunshine, before catching a bus to the University in time for the start of the Conference on Friday afternoon. I was greeted initially by a gaggle of geese, and then a few minutes later by a very warm and welcoming member of the conference organising team. Indeed the tone of the whole weekend was quite informal, relaxed and friendly, and it was easy to chat and meet with other delegates.

I found the opening plenary session (Protecting our virtue(s): medical sociology at 50), particularly stimulating and thought-provoking. It wasn't just the content of his presentation, but his delivery that kept delegates fully engaged, and was a model of good practice.

I have a particular interest in men's health and masculinities, and was therefore drawn to presentations related to this area. I particularly enjoyed a presentation on 'doorwork (bouncers), violence and risk', which was an ethnographic study that explored for example men's 'bodily capital' and the relationship between violence and masculinities. Another fascinating presentation explored how new masculinities are being explored in contemporary South Africa, and the effects on men's lives. Despite being a little tired on Sunday morning, I enjoyed a presentation on men's transition to fatherhood, and the perceptions and experiences of first time fathers. One of the most valuable things about the weekend was having the opportunity to speak to presenters after their presentations, or during meal times. This allowed for much healthy and stimulating debate.

The other aspect of the Conference that I felt really benefited me, was learning how the rationale for different study designs evolved. Being a year into a PhD, this was a really useful learning experience for me, particularly in the context of validity and reliability issues relating to qualitative methodologies. It enabled me to reflect in a more critical way on my own work, and provided much food for thought in how to proceed with my work.

Rarely did I feel at a loss or out of my depth during the weekend. I left York feeling invigorated and determined to submit a paper for consideration in 2004.

Noel Richardson; PhD Student
University of the West of England

REVIEW OF 'PAIN' EXHIBITION

Pain, Passion, Compassion, Sensibility. A Wellcome Trust Exhibition at the Science Museum

Introduced by Hannah Bradby
Department of Sociology and Leicester-Warwick Medical Schools
University of Warwick

The press preview of the exhibition on pain started at 12 noon. Our party arrived at 11:45 and was sent back from the registration desk to compete for views of early telephones and turbines with a rush of highly enthusiastic primary school children. Already we had failed to act the part of a press pack. We were six postgraduate sociology students from the University of Warwick (pens poised over spiral-bound note pads), some of whose reviews appear below and me, the teacher (wearing a hack-style Macintosh). But despite the students' pads being identical to those used by the real journos, our disguise failed. Our eager early arrival, diligent note-taking and close engagement once admitted to the display, must have betrayed too much interest in the subject matter. Perhaps it was one student's sardonic laughter which alerted the *BMJ* journalist to our masquerade. The curator (Javier Moscoso) and the Wellcome head of exhibitions (Ken Arnold) were being interviewed at the time, so the representative from the *BMJ* asked Ms Sardonic for her views on the exhibition. Her response, 'S'awright I suppose', demonstrated an admirable refusal to give him what he wanted - something publishable.

Meanwhile a woman with a paintbrush and a wet emulsion lid was whiting-out the screw-heads on the displays and the Museum press officer was asking the real journalists for their affiliation (The Biochemist and The Higher were in attendance). Ninety minutes later the students and I were still looking at the pictures, glass boxes, video-loops and slide shows, trying to interpret the lay out - chronological, historical, redemptive, random? The journos had sloped round quietly bored and sad-looking, appropriately, slightly pained.

The theatre of participating at a press preview heightened our enjoyment of this exhibition. However, as a commentary, statement or illumination of the complex world of pain, it did not work for me, since neither emotional impact nor analytic synthesis was on offer (for a longer review see issue 26.5 of the *Sociology of Health and Illness*). My reaction might have been different had I been in an alternative state; if pain had played a more immediate part in my existence that week, a selection of the material might have grabbed my senses more urgently. Instead it struck me as disparate and focus-free.

Despite my misgivings, I urge you to see this exhibition, since it is sincerely trying to make connections between areas of enquiry and representative forms that are often isolated from one another. And it might move you. And it is free.

The exhibition is the fourth in a series mounted by the Wellcome Trust at the Science Museum and is on display until 20th June 2004. Documentation accompanying this and previous exhibitions is available at: http://www.wellcome.ac.uk/en/1/pinpubactexhhom.html.

Hayley Davies, Department of Sociology,
University of Warwick

Paintings depicted the blood and gore of early operations, agonising childbirth and the suffering of combat. Sculptures and carvings represented the crucifixion of Christ, the fate of eminent

martyrs and of ritualistic sacrifices. Historical artefacts designed for the torture and imposition of social control, as well as instruments designed for amputation, obstetrics and tooth extractions were placed side by side. There was little to distinguish them from each other, indicative of the brutality of early medical intervention. The cumulative impact of the harsh instruments and images of torture, combined with the cold, dark setting and concomitant eerie music gave the exhibition a rather sinister ambience.

Pain was located socially and culturally. The role of pain in the salvation of the soul was presented in stark comparison with the personification of pain as a demonic or bestial character guiding souls into hell and damnation. Pain is depicted here as transcending the mere physiological, a reference to the literature in this area of investigation (Richards et al. 2002; Turner, 2000).

An interesting, if somewhat controversial feature of the exhibition was the inclusion of sadism and masochism. Their presence was perhaps appropriately, given the long history of each, and the historical popularity of sadism, demonstrated in the wide audiences that bull or cock fighting attracted.

The medicalisation of pain is perhaps the apex of the exhibition, as historically this is not only representative of the Cartesian split between body and mind (Bendelow and Williams, 1996) but more importantly an indication of the rising dominance of biomedicine in pain relief/ alleviation. It is also the exhibit's only claim to science. A physiological understanding of how physical pain was experienced, the workings of the nervous system and methods of pain relief were depicted. Interestingly, the exhibition acknowledged the existence of alternative medicines and alternative forms of healing deriving from various historical and cultural backgrounds.

As in much of the literature covering pain, that encountered by children was something of a lacuna. The exhibition also failed explicitly to address the socially constructed nature of pain experiences, which are skewed across socio-economic and gender dimensions (Davies, 2003). Similarly, there was no recognition of gender within the care of those suffering pain.

Furthermore, the exhibition had a very adult-centric approach. It was not only too gruesome and too intellectually advanced for children, but was also a little too explicit. However, it might have some appeal for medics, students of relevant disciplines, or anyone interested in the development of the conceptualisation of pain and parallel medical intervention.

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The objective of the Science Museum's exhibition on Pain was to contribute to a 'public understanding of science' through its illustration of something that one may feel every day. The Exhibition consisted of three rooms, each representing different aspects of pain. The first room

was painted black and consisted of images and objects of medieval torture. According to Javier Moscoso (the curator) this room is meant to represent 'Passion'. This is the pain that one feels when punishing the body for salvation, experiencing torture and from ancient techniques of surgery.

The next room was white, representing 'sensibility' which were attempts at scientific understanding of pain and methods used to alleviate it. Within this room there were cubicles which featured exhibits on self inflicted pain and amputation. The third room was grey and featured images of animal pain, which represented compassion (the ability to sympathise with others' pain). This featured the costume of a matador slain by a bull, illustrating the irony that the slayer feels the pain that he intended to inflict on his victim.

However, from a postmodern perspective (Foucault 1973), the exhibition could have represented the changes of concepts of pain throughout the ages. When I first saw the exhibition I thought that the first room represented medieval and religious notions of pain, which were previously perceived by the liberal scientific community as being part of the 'dark ages' (Copleston 1964).

During the enlightenment period, which I thought that the white room represented, the experience of pain for salvation was no longer seen as necessary since rationality separated the mind from the body (Cottingham 1998). Therefore medical advances were made to alleviate the pain of others. However this did not stop the process of pain, nor did it stop the self infliction of it, which scientists struggle to understand.

Finally, I thought that the grey room represented other cultural understandings of pain, which is more involved with nature. It is grey because unlike the white clinical atmosphere of the other room, under a rational scientific point of view one cannot explain pain from the perspective of other cultures (Shiva 1989).

Although the exhibition was very interesting I still felt unsatisfied with it. This was probably because it is difficult to represent the scope of meaning of pain within the area of three rooms. There were points at which I felt compassion and sometimes nausea at the representation of pain that people have felt throughout the ages; yet it seemed to symbolise only one small aspect of it. The exhibition only represented the most extreme and 'public' type of pain (Helman 2000), failing to notice the private kind. As a result, it could be hard to empathise with the exhibition because it does not represent the private pain that many people may feel every day.

Despite this I would still recommend medics and non-medics to visit the exhibition because it gives an interesting perspective on pain. It illustrates that pain has different meanings according to context and how science has come to interpret them. This is important because it may contribute to everyone's understanding of the darker elements within human nature and science. As Nietzsche said (1990: 72), 'I doubt that such pain makes us "better"; but I know that it makes us more profound.'

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Joseph S. Okpoti
Department of Sociology, University of Warwick

Pain in any form and severity causes great discomfort to any living being. Over the years, I have seen and witnessed the effects of pain in different forms manifested in the lives of people, especially loved ones. Literature on the various causes and reasons for pain enables you to appreciate the role pain plays in our lives. Observing and participating in this exhibition on pain offers you an irreplaceable feeling of how pain has impacted lives from the past to date. It was with this background that I went to the science museum to observe at close hand the development of pain from its historical origin to modern day incidences of pain, and how mankind had developed strategies to cope with it. This was also exciting for me since from a historical African perspective, pain has been associated with wrongdoing and punishment from the gods.

Within the first chamber of the exhibition hall, you get a sense of entering the dark ages and moving back into history. The background music is rather sorrowful and gives you a feeling of being in the place of the dead. The visual observation of torture depicted by the paintings and the tools used to inflict pain on subjects, such as the thumb piercer and boots for holding boiling oil makes you cringe with fear. The crucifixion of Jesus Christ and a painting by P. Fontana showing Salome holding the head of John the Baptist (1797) coupled with the audio presentation brings to you a feeling of compassion for human beings in the past and present who have had to undergo such brutal atrocities. From a medical point of view, you have a sense that the world has come a long way from methods such as amputation depicted by the painting of Thomas Rowlandson appropriately titled 'Amputation'. Your whole body shudders with trepidation and fear when you picture yourself in his position.

In the second chamber, which has been painted white, one immediately gets the feeling of entering a period of enlightenment. The discovery of medical equipment and medicinal drugs to help alleviate pain opens the way for new strategies to combat it. One also has the feeling that there are many different types of medications for pain. The impression is created of the medicalisation of all forms of pain through the production of different medicines and the commercialisation of these products either for profit or other motives. This raises some ethical questions, which have to be explored. As I reflect on these new inventions, my mind goes back to the atrocities and the generation of physical and psychological pain that has been caused by civil wars and diseases such as HIV, AIDS and malaria that are devastating whole communities in Africa. This brings me to the realisation that, although we have come a long way in the fight against pain caused by physiological and human means, there is still far to go in reducing pain to the barest minimum.

This exhibition offers an opportunity for every person to relive the pain experience from the past to the present and it offers us a guide to understanding the root causes and sources of pain in order to avoid repeating past mistakes

Virginia Romano
Sociology Department University, "La Sapienza" of Rome

An exhibition about 'pain' seems to start just before entering the exhibition itself, while waiting to get in and wondering whether one is going to be exposed to something nauseating. Despite all the violence to which we are exposed everyday (movies, news, reality shows), we are still living in a society that denies death and suffering. We have drugs for the pain of the spirit, we have medicines for the pain of the body. We have something to ease almost any kind of pain. We simply do not want pain in our lives.

Despite all this, those who are going to see the exhibition because they like a little 'thrill' every once in a while will be disappointed. 'Pain: passion, compassion, sensibility' is 100% politically correct and does not aim to shock or disgust its audience. It develops as a linear path and is divided into three different rooms, each one of them exploring a different dimension of the concept of pain. The first room, Pain and Passion, is all black and the atmosphere is somewhat creepy. The choice of paths you may follow are numerous, but eventually all lead you to a completely white and bright room, modern-looking in sharp contrast with the church-like atmosphere of the first. The second room, Pain and Sensibility, explores the changes brought by the emerging of modern medicine: the 'sterile' look of the room in comparison to the last symbolizes this passage in a very effective way. The passage to the third room, named Pain and Compassion leads us to a semi-empty room. There are fewer objects displayed than in the first two rooms and this choice seems to be connected with the intention of leaving this space for personal reflections. We find a big screen showing a series of images. The question posed before the slide show is: what does the pain of other people mean to you? I guess the only answers one can find are so personal that they are not easy to share.

The immediate temptation while passing through the different rooms is to interpret this pathway as a chronological development. Pain and Passion (the first room) explores the deep connection between pain and religion: pain as a means to reach the purity of the soul through abnegation. Displayed together with the sacred we have the profane, in the form of the tools of a rudimentary medical practice. A practice oddly similar to torture and, just like torture was, publicly on display to the community. This idea of pain as a public spectacle is difficult for us, citizens of the land of the sacred privacy.

The temptation to look at the display of the exhibition as a chronological development is reinforced as you step into the second room - Pain and Sensibility - dedicated to the way in which pain (and its control) is associated with the development of medicine. The monolithic pain of passion and of torture is fragmented in several specialized pains as medicine starts to label them.

The third room, Pain and Compassion, blocks the temporal sequence in showing the circular shape of the different themes connected to pain. The display examines our reaction to other people's pain and how it may vary - indignation, fear, compassion, piety, laughter, indifference, enjoyment, sexual excitement - but all of which emotions are common to human beings. Pain (like death) and the way we think and act towards it narrates our history and nature.

This is why I think the third room should have had direct access to both the other two rooms. Compassion and passion; compassion and knowledge are aspects of the same thing. That is part of the reason why I do not think the exhibition could be fully enjoyed by someone who is not familiar with the history of medicine and with all those issues connected with its development through centuries. The audience's lacking of a way to contextualize what is shown might end up in a simplistic interpretation of the exhibition. Though presented as a narration it lacks, in fact, an account of the necessary links between medicine's historical phases. A general summary of the main steps in the way we conceptualize the body would have helped a lot to see how the different ways of thinking about pain have consequently changed. A 'professional' could find confirmation in the show. It could help them in visualizing what is usually studied in books, it could work as a source of inspiration in thinking and re-thinking about our conception of pain. However, the critical dimension is entirely absent especially concerning the development of medicine. A symptom of this absence can be found in the second room, where a long display of remedies has been set in a display cabinet. One can find remedies ranging from those originating in ancient Egypt, Chinese herbs, up to the latest over-the-counter products, displayed all together though, as explained by the information plaque, this does not mean they are all considered to have the same value. In fact, the main difference between pre-modern remedies for pain and

modern medicine lies in the institutionalization of medicine and this juncture cannot just be bypassed by a pure declaration of intention. The choice to display all these remedies in the same place speaks for itself. This choice can never be unbiased, no matter what one writes on the information plaque. Modern medicine has in fact developed as a normative power. It monopolizes 'normality', and has the power of labeling what is real (giving it a scientific name and accommodating it within its paradigm) from what is not. The choice not to keep pre-modern remedies separated from modern medicines reveals the lack of depth to the exhibition as its main limit.

For all of these reasons I would recommend this exhibition to anyone interested in expanding their understanding of such a wide issue as pain. It could be a good starting point to stimulate interest in the subject and motivate further readings. It can in fact be a useful tool in the hands of someone who would eventually take inspiration from it without being 'manipulated' or constrained to look at this issue from one single, narrow perspective.

Noriko Uryu
Department of Sociology, University of Warwick

What I saw in this exhibition first were 'torture chairs' which had many knives. Seeing that, I thought about how fear of pain has been used for political domination and social control purposefully. I felt that pain was an important aspect of not only the individual but also the whole of our societies. There were also many religious paintings relating pain. The main meaning of them seemed to be 'to relive pain is divine'. That is, all people can do was just believe in and pray to God. They seemed to have no way to remove their pains by themselves. I was interested in the painting entitled "A tooth-drawer extracting a tooth from a grimacing patient". In the past, operations were conducted without anaesthetics, so this patient was wringing his neck with his scarf to prevent himself from feeling the pain of a tooth extraction.

After the first half of the exhibition, I became afraid of pain so much. Then, the exhibition of anaesthetics, remedies and medicine to remove pain appeared. I felt relieved from the fear of pain, I was thankful that I am in the modern developed world.

Through viewing the whole of this exhibition, I recognised that people have not only experienced pain, but they have also been, inflicting, relieving and watching pain. There are also a variety of feelings; indignation, fear, compassion, piety, laughter, indifference, enjoyment, sexual excitement and so on. It is difficult for me to judge whether to recommend anyone else to visit the exhibition because sometimes such an exhibition might stimulate people's barbarous instinctive curiosities, especially for young people and children.

In addition, I am not sure this exhibition offers a critical take on institutions such as medicine and the pharmaceutical industry. When I walked through this exhibition, I felt the emergence of medicine and pharmacy was very welcome after seeing the fear of pain in the past. I think the written elements of this exhibition could have been improved since sometimes I felt there was not enough to understand the exhibition. In addition, I wanted to have many chronological tables for historical understanding.

ARTICLES

Raging correctly - some reflections on DeVries's rallying call.

Chris Yuill
Robert Gordon's University

In his plenary address to the 2003 Medical Sociology Conference, DeVries (2003) urged medical sociologists to protect our virtue(s) by 'rediscovering' a certain playfulness, if not a uselessness, in our approach to the discipline. He contends that we have hit something of a mid life crisis where pointless internecine feuds over the minutia of methods, status and theory have left us 'flabby' and losing out to journalists when making interesting or provocative points about the sociology of medicine. Indeed, DeVries (2003: 35) is quite disturbingly correct to remind us that some of the pioneering work in the field is slipping into the contemporary history of 30 to 40 years ago, notably the innovative and influential work of Goffman and Freidson.

Perhaps this 'malaise' is a reflection of some of the wider problems facing sociology in general. Recent editions of Network have commented on how sociology has a bad media profile with the general public who are largely uniformed as to what it is sociologists exactly do. In his recent interview with Medical Sociology News (Yuill & Lewis 2003), Mike Hepworth struck a similar note in advocating that we should reclaim the ground that has been annexed by, for example, social geography or cultural studies - disciplines that are sociology by any other name.

I concur with DeVries and Hepworth and further contend that we are just not angry enough and that we are slipping back to the time where the medical was more important than the sociological. This has always been a problem with medical sociology. To some extent in our history we have been the 'statistical servants' of the medical profession, providing more epidemiological rather than sociological analysis of health and medicine. Indeed, at the Medical Sociology 2003 conference a few conversations I enjoyed with colleagues raised the concern that there appeared to be more of a health services research inclination to the conference, with the more critical traditions of sociology being much more muted. This may be a minority impression however.

But there has been another tradition within medical sociology, one where a sense of injustice and anger at the injustice has been the motivation for that tradition. Again, like DeVries I look back at some of the earlier work within medical sociology; alongside Goffman and Friedson, there are also Navarro and Illsley, whose work was passionate, raging at the deeper structural reasons why great swathes of people endure both worse health and poorer health care than they deserve. Further to that point, one could also contend that Engels' analysis of the conditions facing working class people in the mid-1800's should be included in the 'critical tradition' of medical sociology. Engels was quite clear and passionate in his indictment of nineteenth century capitalism; that what he was witnessing was the 'social murder' by the bourgeoisie of thousands of workers. Perhaps if we were to recapture some of that political commitment, and develop some engagement with the wider political issues in society that might provide the 'kick' we need to insert life back into the discipline?

After all, much of what we do concerns the very basics of existence, the actual condition and continuation of our lives: the health of the human body. What we see is the effects of a society that firstly negates a reasonable standard of living for many due to class, race and sex and secondly negates a reasonable standard of health for many. For example, Mitchell et al. (2000) point out that 11,509 lives a year could be saved if various (moderate) reforms - reductions in wealth inequality, child poverty and unemployment - were implemented. The actual ramifications

of work such as this should be considerable. Consider for a minute if a single event such as a terrorist strike or a disaster of some kind resulted in such a high mortality level. The policy response would be of equal magnitude, but unfortunately what we do see in action falls well short of this.

Political elements or ramifications to our work have always been the ghosts at the medical sociologists' table. The obvious example of how politics impacts on medical sociology is the classic Black Report, which outlined much of the architecture that future health inequalities research has followed. With its emphasis on structural and neo-material causes of health inequality it was never going to chime with the individualistic neo-liberal agenda of the then incoming Thatcher government. More ideologically congruent ideas of poor health being the outcome of working class people choosing their own demise gained the ascendancy with the quite moderate, in many respects, demands of the Black Report concerning welfare change slipping into a social policy Siberia. Coburn's (2000) recent intervention into the debate around Wilkinson's psycho-social perspective quite vehemently outlined the particular corrosive effects that neo-liberalism has on health. Its main thrust of 'celebrating' the individual counteracts many of the putative beneficial health effects of social cohesion breaking up bonds of social trust while deepening and widening income inequality.

Eight years ago Wainwright (1996) charted how the demise of the left in its broadest sense, as a result of the factional battles within the Labour Party, saw Tony Benn fail to claim the leadership of the party, and the expulsion of Militant to the collapse of state capitalist countries in the Soviet Bloc, provided the political backdrop for a shift in the emphasis of what was the root cause of health inequalities. The consequences of these wider defeats for a perspective on society that emphasises structure, and the negative effects of the inequality that it creates, did not just affect the socialist left in Britain, but also had an effect on the mood inside academia. As Callinicos (1990) asserts, one of the reasons for the rise of post-modernism in the colleges and universities was that it offered a refuge against the onslaught of neo-liberalism but still afforded a radical guise to its followers. Academics could trundle out as many 'linguistic turns' and 'discursive analyses' as they liked, fully believing that they were producing radical critiques of society. Post-modernism's relativism and obsession with seeing the world as nothing but a constructed collage of texts and words completely ignores that there is a real structured world out there and that it is those structures that have to be dealt with if one wishes to bring about any lasting change.

Neo-liberalism in many quarters has become the orthodoxy and a near hegemonic orthodoxy at that! I feel, however, that there will be another wringing out of political ideology similar to Britain's social democratic defeat by neo-liberalism during the eighties, but this time it could be neo-liberalism that will be on the defensive. Something of a growing consensus appears to be developing that indicates that neo-liberalism does not have the all pervasive sway that some commentators accord to it. On one hand we can witness the large anti-capitalist demonstrations that have been a feature of popular protest early in this century. Seattle 1999 was perhaps the landmark event, where the focus of the wide range of demonstrators fury and criticism was not just a single issue such as the Poll Tax or minority rights, but the whole capitalist system, with the slogan of some protest groups being that 'a better world is possible'. It would be quite wrong, however, to characterise the anti-capitalist movement as a single unified body (Callinicos, 2003), but what it does strongly indicate is a popular disillusionment with capitalism as a whole, particularly in its current aggressive neo-liberal variation. This, coupled with the recent million strong anti-war demos in London, and growing public dissatisfaction with one of neo-liberalism's more high profile advocates, Tony Blair, indicates that there may be an increasing audience who would be receptive to academic work that supports the view that our society requires quite deep structural transformation.

The opportunity to push our discipline forward, capturing both the public and political imagination may be waiting for us, but to take full advantage it may require for us to rekindle more of our critical tradition and to rage (albeit correctly and constructively!) about health issues in contemporary society, reclaiming the territory that we have ceded to others.

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Seeing Through the "Natives' " Eyes: Imposing Categories Across Boundaries

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In this paper I focus on a distinction made by some medical anthropologists in cross-cultural research, namely between disease and illness, and propose that instead of aiding in understanding ill-health cross-culturally, rather it hinders through creating false categories. Although I address the issue briefly towards the end of my paper, I would just like to mention at the outset that when I use "cross-cultural" in this paper, I not only refer to what is classically thought of - say, between Britain and Aborigines in Australia - but also to the different cultures within even local populations.

In her 1997 address at the Society for Medical Anthropology's meetings, Carole Browner discusses her concern for what she calls the "medicalization of medical anthropology" (1999: 135). "By this," Browner states, "I mean the trend among us to study entities as they are conceptualised by biomedicine - cancer, tuberculosis, or arthritis, for instance, or "stress," "PMS," or "postpartum depression" " (1999: 135). This medicalization of medical anthropology, suggests Browner, is not necessarily a negative movement, but a negative consequence of this movement is that "many more medical anthropological studies ... uncritically accept biomedical illness categories and explanations" (1999: 135-136). One major change in medical anthropology has been a narrowing of research scope to focus on biomedically-defined conditions (Browner, 1999: 137). Research now focuses "on pragmatic issues of improving the health and health care situations of contemporary people, both "Western" and "non-Western" " (Pelto and Pelto, 1996: 293). But this focus by medical anthropologists on the improvement of health and health care is done, as suggested by Browner above, by uncritically accepting biomedical nomenclature and nosology.

Of interest to this discussion is Carole Browner et al.'s (1988) earlier criticism of the prominence of meaning, symbolic and epistemological studies by many medical anthropologists. In 1988 these authors suggested that this focus by medical anthropologists has hindered the field's, development: "Yet it has been medical anthropology's strict emphasis on problems of meaning and on health and illness beliefs, practices, premises, and values that has inhibited development of the field" (Browner *et al.*, 1988: 682). They counter that "the critical issue for comparative ethnomedical research is how to "maximize equivalence," that is, how to ask the same question in different settings and how to establish criteria by which equivalence can be asserted" (Browner *et al.*, 1988: 682). But the comparative framework proposed by Browner *et al*. has limited applicability in multiple areas of medical anthropological concerns. Of importance in the context of this paper is that Browner *et al*. admit that their framework cannot "shed light on the nature of "folk" illnesses that have no physiological manifestations" (Browner et al., 1988: 682). Browner et al. suggest that the reason why they restrict their framework to physiological processes is "because physiologically these processes are essentially the same species-wide, with culture impinging minimally as a confounding variable" (1988: 682). This focus on physiological processes reinforces what Tim Ingold (e.g., 1991, 1997) has called the "animal plus" view of humans in which humans are seen as animal, in the sense of their biological body, but are different from animals due to something added on, the "plus" of culture. This view of human beings is distinctly Western, and Deborah Gordon (1988) proposes the division of nature and culture is a "tenacious assumption in biomedicine" which persists in biomedical practice.

Browner *et al.'s* criticism that there is a reluctance on the part of medical anthropologists to explore the interface between biology and culture is reified by their framework in which culture, as mentioned, is "a confounding variable" (1988: 682). The separation of physiology from culture by Browner *et al*. reflects a key distinction, I argue, in medical anthropology: that between "disease" and "illness." This distinction is based on the opposition of nature, or biology, and culture. In the literature, "disease" typically refers to biological structure or functioning, while "illness" refers to the individual or subjective experience. I use "ill-health" in this paper to refer to the basic phenomenon that both the labels "illness" and "disease" refer to in medical anthropological literature since Arthur Kleinman (1980; cf. Hahn, 1984; Young, 1982).

Disease and illness were distinguished "to describe the contrast between the perspectives, or worldviews, of patient and physician" (Hahn, 1984: 1). Illness has been defined as referring "to how the sick person and the members of the family or wider social network perceive, live with, and respond to symptoms and disability" (Kleinman, 1988: 3). This definition places illness purely in subjective terms, allying it with culture. Disease, on the other hand, is conceived in "the narrow biological terms of the biomedical model" in which "disease is reconfigured only as an alteration in biological structure or functioning" (Kleinman, 1988: 5-6). This formulation of disease and illness places the former squarely within the biomedical arena, while the latter can be found in both ethnomedical and biomedical systems.

Although illness can coexist with disease in the biomedical arena, I contend that the disease-illness distinction is in fact a dichotomy. As Robert Hahn points out in his discussion of this distinction, there is "a radical contrast between the "knowledge" of biomedical practitioners and the "belief" of patients everywhere and of traditional non-Western healers" (1984: 2; emphasis added). But although the concepts of "disease" and "illness" are useful in medical anthropology, to acknowledge the differing perspectives regarding ill health, the current formulation of disease as the exclusive province of biomedicine hinders cross-cultural analyses.

Similarly, the distinction in biomedicine between "signs" and "symptoms" reflects the viewpoint of an objective nature in science and the disease-illness distinction: "medicine distinguishes

between "signs," objective indications in the patient's body, and "symptoms," the patient's complaints" (Gordon, 1988: 25). The patient's experience of ill health is aligned with subjectivity giving prominence to the role of diagnosis in biomedicine, which becomes "the interpretation of the patient's symptoms by relating them to their functional and structural sources in the body and to underlying disease entities" (Good, 1994: 8). In other words, "Disordered experience, communicated in the language of culture, is interpreted in light of disordered physiology and yields medical diagnoses" (Good, 1994: 8). We see here an evident connection between subjectivity and culture. Moreover, the attribution of objectivity to the biomedical practitioner and subjectivity to the patient creates "two different ways of knowing - subjective awareness and direct observation" (Kirmayer, 1988: 59). "The patient's subjective account of distress," states Laurence Kirmayer, "was deemed unreliable and essentially irrelevant to the physical diagnosis. Thus, the conscious awareness of the patient was subordinated to the physician's privileged knowledge" (1988: 59; emphasis added).

Kirmayer suggests that this is the real dualism - "between the physician as active knower and the patient as passive known" - and this real duality "is captured in the distinction between disease and illness" (1988: 59). What we have, then, is a knowledge hierarchy in which the objective biomedical knowledge is elevated above subjective cultural knowledge. This knowledge hierarchy in biomedicine has serious ramifications in the cross-cultural study of medical systems, as Hahn suggests that the act of interpretation in cross-cultural analyses is influenced by "the interpreter's assumptions about the rationality and motivations of the local population and about the way the world works" (1995:109). "Such assumptions," continues Hahn, "derive from the observer's own cultural tradition" (1995:109). The privileging of medical knowledge, through this knowledge hierarchy, has an important ramification for medical research and involves the attribution of irrationality, or false beliefs, to patients.

The creation of a hierarchy of knowledge, through the devaluation of patient's subjective knowledge, creates a notion of "rational behaviour." Since scientific rationality is based on the notion of "nature," and therefore is seen as objective and universal, other modes of thought that do not correspond to standards of this rationality are dismissed (Tambiah, 1990:151). This scientific rationality is important with regards to patient compliance. Combining this rationalism with the paternalistic attitude of the biomedical practitioner, "in which the physician, better than the patient, may be thought to know and judge what is best for the patient" (Hahn, 1995: 143), means that when a patient fails to comply with the requests of the biomedical practitioner they can be labelled as "irrational" (Young, 1981). In other words, since the biomedical practitioner's knowledge is "better," because of its objective and scientific bases, it would be "irrational" for a patient not to follow the practitioner's instructions. Furthermore, since biomedical knowledge is "better" than subjective knowledge it is believed that the objective and universal standards of biomedical knowledge can be used to evaluate other medical systems (e.g., Armelagos *et al*., 1992: 42).

But to blindly, or uncritically, use biomedical categories - "disease" - reifies these categories and hides the fact that they are not, as Michael Taussig argued, " "things-in-themselves", [they] are not only biological and physical, but are also signs of social relations disguised as natural things, concealing their roots in human reciprocity" (1980:3). Moreover, Taussig contends that "by denying the human relations embodied in symptoms, signs, and therapy, we not only mystify them but we also reproduce a political ideology in the guise of a science of (apparently) "real things" " (1980: 3). Through this objectification of biological and physical processes the political power of biomedicine has increasingly expanded through the growing medicalization of everyday life, as Irving Zola (1972) argued, to become a major institution of social control (see also Foucault, 1991).

A brief, cross-cultural example of how the distinction of disease from illness, or the use of biomedical categories cross-culturally, hinders research is with the case of congenital hip dislocation among the Navaho, a native people in North America (see McDermott et al., 1969). This dislocation of the hip is considered a disease in biomedicine. But among the Navaho it is the opposite and is not even considered a "particularly important disability" (McDermott *et al.*, 1969:129). The solution lies not in getting rid of these concepts, but in their reformulation. There are different conceptions regarding ill health throughout the world but we need a language that does not give special status to biomedical knowledge. This is the challenge for medical social scientists.

The distinction of disease from illness also represents an academic division of labour, according to Lorna Amarasingham Rhodes who suggests that this distinction is based on a segregation of biomedical and medical anthropological ways of knowing (1996: 171). Rhodes argues that a majority of the research in medical anthropology "is based on a bracketing of biomedical expertise as referring to areas of knowledge not within the purview of the anthropologist" (1996: 171). As Kleinman has suggested, "The illness/disease distinction provides medical social scientists with ... an autonomous subject matter that has been virtually unstudied in medicine - the nature of illness experiences and problems" (Kleinman, 1986: 231). Thus the medical social scientist is seen to properly study culture while the biomedical researcher studies biology.

Returning to Browner's (1999: 135) point about the "medicalization of medical anthropology" that I mentioned at the outset of this paper, the above discussion also has implications for research within biomedical settings. Recently, medical anthropologists have argued that biomedicine is not a single entity. Annemarie Mol and Marc Berg suggest that the image of a unified biomedicine dissolved "when anthropologists started to undertake empirical studies of health care within North American and Europe" (1998: 4). They point out that instead of a single biomedical belief system or culture, anthropologists found "a conglomerate of highly divergent practices" (Mol and Berg, 1998: 4-5). In another context, Mary-Jo DelVecchio Good attempts to explain the phenomenon Mol and Berg encounter suggesting that there are global-local interactions: These local worlds of biomedicine, however, are 'transnational' in character. They are not cultural isolates, biomedical versions of indigenous healing traditions. Rather local meanings and social arrangements are overlaid by global standards and technologies in nearly all aspects of local biomedicine. (1995: 462) This biomedical amalgam is important for more local research projects. One implication involves the researcher and "locality."

Rhodes (1996: 165) points out that one difficulty in studying biomedicine is with the intimate connection researchers have with this medical system; as, often, the researcher investigating biomedicine comes from a society in which biomedical explanations and treatments for ill-health are dominant. Thus, the researcher is not only an observer but also a participant in the culture of biomedicine (Rhodes, 1996: 165). The question that arises from this is if "biomedicine" is, in fact, "biomedicines" how do we know where the boundaries are between each one? Can we talk of a "European biomedicine," or a "Scottish biomedicine," or are there finer distinctions? If so, where does a particular biomedical category from one location, or culture, match and where does it not? As well, Byron Good argues that "grounding cross-cultural analysis on practices current in contemporary biomedicine may produce findings more artefact than real" (1994: 23). In other words, if we use current biomedical practices and categories in research there is a risk of producing misleading, and potentially false, conclusions. Although Good is discussing the use of biomedical categories in cross-cultural research, if it is indeed possible to discuss the multiple "cultures" of biomedicine, then Good's point should apply to all research on medical systems and practices.

Let me finish off with a more tangible example from my own interests on the mental disorder commonly known as Attention Deficit Hyperactivity Disorder (ADHD) which, quite appropriately in the contexts of my discussion, is possibly more commonly known in the United Kingdom as Hyperkinetic Disorder (e.g., Swanson et al., 1998). This disorder is characterized by three traits, or behaviours: inattention, impulsivity and hyperactivity (Biederman et al., 1997). The difficulty in doing research on this disorder is twofold. First, the rating of what are considered abnormal levels of these traits, has been shown to be biased by the practitioner's cultural standards (Mann *et al*., 1992: 1542). Second, and possibly more importantly, the traits are considered abnormal only insofar as they are "maladaptive and inconsistent with developmental level" (American Psychiatric Association, 1994: 83-84). In other words, the behaviours have to be considered problematic. How then does one do research on this disorder? If one adopts a top-down definition does a researcher not "produce findings more artefact than real," as Good suggested above (1994: 23)? Is, then, a researcher possibly better served by taking the "native's" perspective on who is and who is not ADHD or any other category?

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Phil Strong Memorial Prize: Women war survivors in Luwero District, Uganda

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The effect of the constant aggressive rapes left me with constant chest, back and abdominal pain. I get some treatment but still, from time to time it starts all over again. It was terrible. (Woman discussing the effects of war during a Kamuli focus group, Interview P47)

Background

Uganda has experienced civil wars since gaining independence in 1962. Between 1981 and 1986 gross violations of human rights occurred during the protracted bush war against Obote's regime. This involved Museveni's army and had its starting base in Luwero District. Hence, this area was particularly affected. Although Luwero is now relatively peaceful, research has shown the population still suffers physical and psychological effects (Musisi *et al*. 2000).

A previous intervention project with women war survivors in Luwero concluded: 'The effects of the war on the women have impeded their daily functioning and impacted on the low socio-economic development of this region despite massive infra-structural and economic rehabilitation efforts by the government' (Musisi *et al*. 1999:4). It recommended: A psycho-traumatic treatment programme be implemented as a matter of priority for these war survivors. (Musisi *et al*.1999:4). However, proposals for services have not yet received funding. I therefore decided to pursue this area of research for my Ph.D.

Research Questions

These were in three thematic areas:
1. What are Ugandan women's experiences of violence, rape and torture during civil war years in Luwero?
2. What are the effects of women's experiences?
3. What are the resulting needs of women in terms of health policy, welfare and human rights?

This brief article details key findings presented at a workshop held in Kikamulo Sub-County, Luwero on 18th December 2003, organised in conjunction with Isis-WICCE, an international women's non-government organisation, together with local women leaders. It included a local drama group, representatives from the Ministry of Health, rotary club, non-government organisations, local and central government. **Gaining the Phil Strong Memorial Prize enabled this workshop to take place**. Research participants attended, goats were donated and medical treatment provided, using money raised by the Older Feminist Network of South Wales.

Findings were based on extensive analysis of 99 interviews carried out in five parishes of Kikamulo, three of which were focused on in detail. Focus group discussions were held with women and men volunteers and individual interviews were also carried out. We discussed what took place during the war, the effects of their experiences, and views about current needs. Key informants were also interviewed.

Effects of Women's and Men's Experiences: Key Themes

> *I was thirteen years old when the war started. We were still in Kiwoko. Obote soldiers came after the voting. When Obote won the elections, they started looting and killing people.* (Woman from Kamuli, Interview P36)
>
> *For men, they were killed and the women mostly cut and raped.* (Man from Kamuli, Interview P29)

The war caused:

1. Economic retardation: property, houses, land, crops, livestock and productive resources were destroyed with devastating effects, as a man from Wakayamba described:

> *My riches were taken. I had twenty-seven cows, which were all eaten. My shop was demolished and looted of a sewing machine, weighing scale and two bicycles. I am now left with nothing to lean on.* (Interview P83)

Extreme torture of men and women left many unable to work due to enormous physical and psychological effects.

2. Damage to social fabric and society: families were forced to leave their homes and land. Women and young girls were abducted and used as sexual slaves. Social and political networks were destroyed and families and communities broken up. Social devastation had dramatic effects on gender roles. Death, sickness, injuries and torture of relatives, friends and neighbours caused absence of men. John, from a non-government organisation, described how war changed relationships between women and men:

> *The situation has left women as breadwinners because many men died. As the social structures have been destroyed the family head traditionally should be the man, but now the woman takes over the role. Even if the man is there he does not have the moral authority to give direction to the family, as he cannot provide for them. He could not defend his own children and family, many of who were abducted, in front of his own eyes. That is quite dehumanising for a man and has a lot of psychological effects.* (Interview P100)

3. Damage to culture: Acholi[1] soldiers attempted to destroy Baganda culture by targeting cultural practices, rituals, and disruption of customs and practices that traditionally embody cultural values. Women were viewed as the sexual, reproductive and labour property of men and therefore targeted. Acholi soldiers caused sexual dishonour of Baganda women through rape and sexual violence, abduction, forced marriage, sexual slavery and of both women and men through forced incest. A woman working in a non-government organisation described the experiences of one woman who took up arms to fight for peace and suffered multiple gang rapes by Acholi soldiers:

> *Rachel: This girl who was gang raped...she recalls 21 but she could not remember how many raped her. One time they were closed up in a certain room and she was raped day in and night. So this young girl tore and there was no separation between the vagina and the anus. Now this girl contracted HIV and by the time we went...it had already blown to AIDS.* (Interview P10)

This woman has since died (Isis-WICCE, 1999: 11).

Genital Mutilation

Genital mutilation, particularly by 'cutting,' was utilised by Acholi soldiers as a gender-specific violation during the war (Liebling, 2003). It has also been documented in the northern region of Uganda (Isis-WICCE, 2001: 20). Some women were young girls during the war like Susan, a 32-year-old woman from Kasana:

> *During the war army men made my father sleep with me and when he refused they tied him with ropes, put a pistol to his head and made him lie down on me. He tried to penetrate me but he could not as the army men pierced me down below with a pistol and he saw the blood and lost desire. They took my father aside, shot him with a bullet in the chest and he died.* (Interview P71)

Reproductive and Gynacological Health Effects

Women's experiences of sexual torture left them with very serious gynaecological and reproductive health needs and Isis-WICCE concluded:

> Since women were sexually targeted during the war, many of the crimes against them resulted in the damage of their reproductive organs or problems with sexually transmitted diseases including AIDS. (AGOU, 1999: 4)

The current study supported these findings (see Liebling, 2003). A woman from Wakayamba discussed the effects of gang rape:

> *Since the rapes I developed stomach problems. When I got pregnant after being raped the time for delivery came and my uterus came out but after treatment it went back but the pain did not end. Eventually I really got sick and the uterus was removed. Now I have persistent backaches and itching in the private parts*. (Interview P95)

Some women interviewed bore children from rapes they endured. Bearing a child from rape evoked immense distress (Nordstrom, 1991; 1993) and resulted in the breakdown of family and community functioning (Sideris, 2000). One woman from Kasana who bore a child following rape said:

> *I was greatly affected and I was taken care of using local traditional medicine...I healed well but they had left me pregnant and I contracted syphilis. When I started working in Kiwoko hospital I was treated and healed but whenever I am in my period, I feel a lot of pain and a sore developed which hurts a lot and I itch around the private parts, which smell. I produced the baby and named her Samanya Agnes. I did not know Agnes, but she died at two years from diarrhoea and body swelling.* (Interview P73)

Silence and Stigma

The silence that surrounds women's experiences of sexual violence during war is supported by previous research (see Swiss and Giller, 1993; Sancho, 1997). It took Isis-WICCE, two years of careful sensitisation before women in Luwero would talk about their experiences (Lubanga, 1998; Musisi et al. 1999). A woman worker stated:

> *Rape is seen as a shameful act that stigmatises the women and as a result they do not have the freedom to talk about it. Many of them suffer in silence and therefore they become traumatised and you find that many of them are getting headaches. They get diseases that result from trauma and suffer physically.* (Interview P8)

Psychological Effects

This study found a vast array of psychological effects in women and men. For women, these included symptoms often associated with Post Traumatic Stress Disorder e.g. intrusive thoughts, flashbacks, nightmares, disturbed sleep patterns, anger outbursts, difficulty concentrating, diminished interest in daily activities, anxiety problems, avoidance behaviour and detachment from others. Similar symptoms were found in a previous study (Liebling & Kiziri-Mayengo, 2002: 555). The current study found several other effects to do with changes in identity, including low self-esteem, being unable to resume a sexual relationship, isolation and being unable to trust men.

Women's Strength and Resistance

Although vulnerable to sexual exploitation during the war, women in Luwero demonstrated considerable agency and resistance (Liebling, 2003). Some took up arms; others assisted Museveni's soldiers and adopted what Boric terms the role of 'mother-heroes' (Boric, 1997: 40). A 36-year-old woman from Kasana was a young girl when the war started and chose to fight in order to protect herself from rape. She said:

> *The Obote soldiers used to come and take girls so I said to myself 'I'll not be here to be cut or taken...let me join Museveni's guerrillas'. I went to Kyamutakasa, training for the Guerrillas for six months. The training was very hard, but at least I wasn't being cut. We were six girls all together. I finished my training, got my papers and identity card and came back to my parents who said I had finished the training very well.* (Interview P17)

Women felt their war contribution helped bring peace to Luwero. They spent much of their time during and after the war focusing on caring for others, particularly their children. Perhaps focusing on the needs of others helped them deal with their own war experiences? Several women interviewed ran income-generating schemes, businesses or became involved in politics.

However, during the war medical services were totally disrupted and attempts at treatment did not materialise and were soon phased out (Bracken et al. 1990; Bracken and Petty, 1998; Musisi et al. 1999). Gynaecological and reproductive health services are still grossly lacking for these rural women constrained by poverty.

Taking Action

Local women's attempts to get justice for atrocities committed against them have proved difficult, as a woman leader described: *Eleanor:*

> *Some women tried but they were defeated. One woman went to Court in Luwero but her case was not forwarded. That was in 1998 and she was told that the law did not exist within our Ugandan laws.* (Interview P16)

Despite this, some women had taken action on behalf of their daughters but they were far from satisfied with the outcome.

Summary

- The forms of violence utilised by Acholi soldiers during the civil war were not random but constituted a gendered form of genocide causing devastating economic, cultural and social destruction.
- War trauma, in this context can be understood as a breakdown in cultural identity manifested in psychological, physical, social and cultural effects.
- Although both men and women were tortured, women were more likely to be subjected to sexualised violence. Men were more likely to be targeted for annihilation by torture and murder. Significantly greater numbers of men died, leaving behind huge numbers of widows, children and orphans
- Women were infected with sexually transmitted diseases and HIV/AIDS. There was serious damage to their reproductive organs. The stigma associated with sexual violence within African culture is immense, and many women suffer in silence (Liebling and Shah, 2001; 2002). However, women spoke openly in the current study and at times it seemed that their depression lifted. They also demonstrated agency and resistance, leading to positive changes in gender roles (see El-Bushra, 2000) * Legal redress was rare and unsuccessful, and compensation following the war failed to reach women (Lubanga, 1998)

Recommendations

1. Priority should be given to establishing specialist gynaecological and reproductive health services in Luwero. Women's specific needs should be incorporated into current health

policy (AGOU, 1999). There is a continued need to voice the experiences of women in war as this knowledge can help challenge structures that prevent them accessing the assistance they require (Liebling and Kiziri-Mayengo, 2002).

2. There is a pressing need for gender-sensitive health, welfare, and legal services for women and men war-torture survivors and their families in Luwero using empowerment principles and building on local initiatives (Musisi et al. 1999; Liebling and Kiziri-Mayengo, 2002; Liebling, 2003).
3. Training and sensitisation programmes on the effects of war should be provided for government officials, local leaders and health workers on the effects of war.
4. Income-generating activities and increased political involvement of women in peace negotiations should be encouraged.
5. Legal redress and compensation for human rights abuses should be actively pursued using international laws that recognise rape as a war crime. Women's resulting health needs should be viewed as a human rights issue (Short, 1997; Short, 1999).
6. Education should be provided at all levels to ensure the human rights of men, women and children are protected during and following war in Uganda.
7. Further research should be carried out to assess the level of HIV/AIDS infection as a result of sexual violence women suffered during the war. This should be combined with counselling and treatment for those affected.
8. Research is also required to more adequately assess the needs of men, orphans and children following war.

Acknowledgements

Special thanks to the women, men and key informants who spoke openly about their war experiences. I give my sincere appreciation to all those in Uganda and the UK who assisted with this study. I am also grateful for the contribution of this prize and Dr Gillian Bendelow's support.

Note

1. Obote's army was mainly composed of soldiers from the Acholi ethnic group, Northern Uganda.

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Referencing Flemish, Dutch and German authors in English

Students and colleagues often ask me, especially when using the Harvard System: 'How should I reference your name when quoting one of your papers?' There is some confusion about referring to Germanic names with particles, especially since Flemish, Dutch and German speakers use them differently from each other, and emigrants from these countries to English-speaking countries use references to such names differently again.

German names

German names are sometimes preceded by the particle 'von' or occasionally 'van' (in a family of Dutch descent), for example the World War I general *Paul von Beneckendorff und von Hindenburg* (better known as Paul van Hindenburg) or the composer *Ludwig van Beethoven*. "As a rule, when the surname is cited alone in English, the particle is dropped" (Trask 2002: 135). So one reads about *Hindenburg's* victory or *Beethoven's* Sixth symphony. Under the Harvard System these particles follow the author's initials (Bett 1953: 17), although it is perhaps clearer to an English-language audience to keep the family name and particle together (see Box 1).

Dutch and Belgium names

Dutch names can have a range of different particles, the most common one is 'van'. Also possible are, for example: 'de', 'van der', 'van den', 'van het', 'op het', or their abbreviated forms such as: 'van 't', 'op 't' or 'v/d'. In the Netherlands, the particles take no capital letter, for example: *Ruud van Nistelrooij*. According to Trask (2002: 106) in Flemish-speaking Belgium (and South Africa) it is more usual to capitalize particles, for example: *Paul Van Look*.

In contrast to German, Dutch particles are always included when the name is used in the text. So, for example, *Vincent van Gogh* is referred to as *van Gogh*. Unless the name is at the beginning of the sentence, for example, two Dutch football players: '*Van Nistelrooij* and *van der Vaart* celebrated the second goal ..' or '*Van der Vaart* and *van Nistelrooij* celebrated ..' However, similarly to German, "particles are ignored when placing names in alphabetical order" (Trask 2002: 106).

Surnames of immigrants in English-speaking countries

Family names of Dutch emigrants to English-speaking countries are often changed to suit the local style. So in the US we find medical sociologist *Ray DeVries* as well as *Dick Van Dyke* and *Gloria Vanderbilt*. American names would be listed under the particle. So alphabetically *Van Dyck* is listed after *Vanderbuilt*.

Box 1. Examples of referencing Flemish, Dutch and German authors in English

German names	- Beethoven, L. van (1817) etc. - Beethoven van, L. (1817) etc.
Dutch / Belgium names	- Gogh, Vincent, van (1891) etc. etc. - Look, Paul, Van (2002) etc. Or keeping the family name and particle together: - Gogh van, Vincent (1891) etc. - Look Van, Paul (2002) etc.
American names	- Vanderbuilt, G. (1998), etc. - Van Dyck, D. (1968) etc.

However, if you are writing a journal article, check the journal style. Often journals will list all names in alphabetical order of the particle, in the same way that the UK telephone directory does. Thus *van Teijlingen* is listed under 'V'.

I am sure there is similar confusion around referencing of names from languages derived from Latin, such as d'Silva, La Rochefoucauld, Simone de Beauvoir, Jean de la Fountaine, or María Eva Duarte de Perón. Hopefully someone else will help clarify these for Medical Sociology News.

Edwin van Teijlingen
University of Aberdeen

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PhD REPORTS

Inside Stories: The Myths behind End-of-Life Medical Treatment Decisions in the UK

By engaging in a unique cultural and temporal approach, this thesis aims to elucidate the apparent increasing disparity between public expectation of what end-of-life medical care should entail, and what appears to be the standardised medico-scientific response to death and dying. Legal, medical and ethical debates regarding end-of-life (eol) medical treatment decisions in the UK have raged for several decades despite such efforts as medical school training aimed at improving doctor-patient communications and developing guidance on withholding and withdrawing life-prolonging medical treatment. Much of the problem appears to be a result of privileging objective scientific *a priori* knowledge over subjective individual beliefs about death and dying regarding end-of-life treatment decisions.

Through the investigation of Western medical symbols such as the Asclepian staff, medical caduceus and Christian Cross, along with a new symbol of medicine, the myths and ideologies of death these symbols represent are revealed. In turn, it is argued that, although there is a 'superordinate goal' or mission of medicine (Deal & Kennedy: 1982), there are four distinct medical ideologies of death which can be used to interpret that mission in the eol decision. Additionally, a 'non-linear' approach utilising aspects of quantum theory is used to contrast and compare the myths and symbols in linear (historical) time, cyclical (sacred/repeatable) time and spiral (relational) time. This approach reveals a dialectical relationship between time and death that shows up as a cycle. Each ideology of death, therefore, emerges as a dominant discourse within this cycle during the Hellenistic, Early Christian, Renaissance, and 20th Century periods; and is signposted by the commensurate medical symbols and concomitant myths.

This thesis provides the first collective study of the symbols of Western medicine using a cultural-temporal approach. Visual and discourse analysis is used to determine the 'hidden' values and beliefs about death represented by the symbols of the Asclepian Staff, representing death is an enemy; the Christian Cross, representing life is a sacred gift & death is an enemy of the 'unsaved'; and the Medical Caduceus, representing human sacrifice benefits all humankind. Lastly, this thesis introduces a new symbol to emerge at the periphery of medicine in the 20th Century-the circle-cycle, representing the ideology that death is part of the cycle of life. Collectively these symbols and myths disclose 'medical attitudes' towards death which may or may not come into conflict with the dying patient's and his/her family's attitude toward death regarding the end-of-life medical treatment decisions.

Judith R. Wester, **Department of Sociology & Centre for the Economic and Social Aspects of Genomics, Lancaster University**

Explaining gender divisions of labour in physiotherapy and radiography: a qualitative study

In this sociological study, physiotherapy and radiography are examined as two predominantly female health professions. The emergent objectives of the research were to explore experiences of women and men within the professions and to consider and compare 'insider' and 'academic' explanations for the gender composition and divisions of labour in them. The research is framed within the methodological traditions of interpretivism and feminism, and uses iterative methods

of data collection and analysis informed by grounded theory and analytic induction. The thesis begins with an extensive examination of feminist and traditional literature on sex, gender and sexuality; education; work and employment; caring and professions. The literature review both informs and is informed by the detailed analysis of qualitative data from 48 semi-structured interviews and 69 postal questionnaires. The fieldwork was conducted with student and qualified members of the two professions. The coded data are compared by sex and occupation, and organised into conceptual categories and constructs. Main themes and core issues are identified as relevant to the gender composition and divisions of labour and, from this, an explanatory theoretical framework is proposed. The Nud*ist software package has been used to aid the data analysis. The overall gender composition and horizontal and vertical divisions of labour within the two professions are seen to reflect impressions, evaluations and experiences of the 'caring', 'professional' and 'career' aspects of physiotherapy and radiography involving hierarchical, dichotomous notions and norms of gender and sexuality. These notions are variously identified as relevant to the gender composition of the professions at recruitment stages, during training, and after qualifying. In particular, caring and different types of care-work are experienced and evaluated in terms of various associations with female gender roles and responsibilities, feminine characteristics and abilities and sexuality, and linked to activities of the private/domestic sphere that use limited skills and informal knowledge. In contrast, professions and professionals and employment careers are linked to male gender roles and responsibilities, masculine attributes, activities of the public sphere, and rely on expert skills and achieved, formal knowledge. These contrasting aspects of physiotherapy and radiography theory and practice invoke different status. The author concludes the professional status and the gender composition of physiotherapy and radiography reflect the inherent gender-based contradictory status of their work and identity as 'caring professions'. Caring represents a problem for professional status at both the individual and collective level: 'caring professions' involve a contradiction in terms.

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Supportive Care: Experiences of Cancer Patients and Health Care Professionals

Cancer is the most feared of diseases (White and Macleod 2002), two in five people are affected at some stage in their lives (CRC 2002). With the increasing incidence of cancer and longer survival times (ONS), cancer care has evolved from focusing on survival to maintaining or improving quality of life (Ferrans 1990). Thus the need to explore the nature and provision of 'supportive care' for patients with cancer has become paramount. The Calman-Hine Report (DoH 1995) and NHS Cancer Plan (DoH 2000), designed to improve the quality of services to cancer patients have led to the establishment of cancer networks, improved dissemination of information, collaboration and close inter-professional communication, all of which aim to maximise supportive care for cancer patients. But despite a considerable body of knowledge into patient reactions to cancer and its specific stages, supportive care remains an area that is complex and in need of further investigation. (Burke 1996, Chan 2001). Some studies have investigated supportive care and individual reactions at different stages of disease (Boer et al 1999, Faithful 1999), but studies involving patients' and professionals' experiences of 'supportive care' are scarce in the literature (CHI 2001 survey). Few studies have investigated patients' experiences of supportive care at different stages of the disease process together with the quality of and patient satisfaction with supportive care services.

This study investigates how patients with cancer and the health care professionals caring for them perceive and experience supportive care at different stages of the disease trajectory. It aims to explore how cancer patients perceive and experience supportive care, to identify how health care professionals caring for cancer patients perceive supportive care and critically analyse current supportive care service provision and utilise the findings to develop a model of supportive care for patients with cancer.

Purposive sampling was used to select patients from a palliative care outpatient department at a Marie Curie Centre. The qualitative data from two focus groups was analysed using the QSR*NUDIST software data package to identify emerging themes. Eight major themes were extracted; these involved issues and needs concerning diagnosis, information, acceptance of cancer, having a named person, being involved in choices regarding treatment and care, limited resources, feeling unsupported and user involvement led supportive care. The major themes were used to develop a questionnaire. The EuroQol quality of Life measure (Kind et al 1998), the Mental Adjustment to Cancer Scale (Greer Morley and Watson 1989), the General Hospital Questionnaire 12 for psychiatric screening (Goldberg 1970), and the MOS Social Support Survey (Sherbourne and Stewart 1991) supplemented the questionnaire to provide patient outcome measures.

Fifty questionnaires were administered and preliminary descriptive analysis of the data revealed some interesting findings regarding choices of treatment and care, informational, psychological and financial needs which will be explored by further statistical analysis. Five in-depth interviews with patients facilitated a search for explanations of the relationships found in the quantitative data and five in-depth interviews were also carried out with staff to compare their perceptions of supportive care. Further analysis of the data collected in the three research phases is planned to identify critical periods in the disease trajectory when supportive care needs are paramount. It is proposed to develop a model of supportive care from the domains of care needs found in the data which will include the following; physical, social, psychological, spiritual, informational needs, being treated as an individual human being, being empowered, receiving continuity of care within an integrated service and having a named person.

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High Technology Medicine in Practice: the Organisation of Work in Intensive Care

The aim of this thesis is to develop a grounded understanding of the practice of high technology clinical work and how it is organised. It combines systematic empirical analysis of the clinical locale of intensive care with scholarly work in medical sociology and the related fields of health services research, medicine, nursing and social studies of science and technology. The empirical data were obtained through fieldwork on three intensive care units (ICUs). The methods comprised periods of detailed observation, informal conversational interviews in the field and tape-recorded semi-structured interviews.

The substantive contribution of the thesis is an analysis of contemporary and traditional themes in medical sociology: medical uncertainty; clinical knowledge in practice; inter-occupational relationships; the material and social character of medical and nursing work; and the organisational 'reality' of one clinical site within the modern hospital. In particular, the thesis demonstrates the utility of 'craft' as a metaphor for understanding medical work in ICU; provides

a critical empirical review and reformulation of nursing theory as it has been applied to ICU; and proposes a new conception of the relationship between medicine and nursing in the grounded situation of clinical work.

Two subsidiary contributions are also made: one methodological and one theoretical. In terms of methodology, I provide concrete examples of how ethnographic analysis can explain findings which have been derived from other health services research methods and thereby inform the future direction of such research. In terms of theory, I illuminate current debates at the interface of medical sociology and social studies of science and technology about the appropriateness of a post-structural style of analysis. In conclusion, I specify in what ways our understanding of health care work is - and is not - enhanced by the adoption of Actor-Network Theory.

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Acculturation in Canada: the use of traditional medicine among Ghanaians in the greater Toronto area

This thesis registered at the University of Aberdeen, studied Ghanaian immigrants in the Greater Toronto Area (Canada), considering how acculturation was related to attitudes and usage of Traditional Medicine (TM). A total of 512 questionnaire interviews were conducted in addition to three focus groups of nine participants each. Both quantitative and qualitative methods were used and frequencies, percentages and simple chi-square were used to analyse the quantitative data while "content analysis" was used to analyse the qualitative data.

Five main hypotheses were tested, that: 1) Ghanaians have a generally positive attitude toward TM; 2) there is no significant relationship between Ghanaians who were born in Ghana and those who were born in Canada; 3) there will be a significant difference between Ghanaians who have lived longer in Canada and those who have lived shorter; 4) there will be no significant change in the attitudes and opinions of Ghanaians as a result of their staying in Canada; 5) there will be significant differences in attitude change toward TM between Ghanaians in terms of educational and income levels, age, gender and marital status.

Ghanaians have positive attitudes toward TM, and they operate within a 'Personalistic Medical System'. There was no relationship between variation in attitude toward TM and sex, age, marital status and place of birth. However, there was a relationship between change in attitude toward TM and level of income, educational, ethnic group, religion, and number of years in Canada.

In terms of acculturation (more in line with 'inculturation'), Ghanaians have been pursuing "integration" and "assimilation". There is no evidence to suggest that traditional beliefs have been undermined to such an extent that there is a change in attitude toward TM. There is an increase in the number of "faith healing" churches in the GTA as part of the health seeking behaviour of Ghanaians. If the ultimate aim of acculturation is towards "modernity", then Ghanaians have not fully acculturated into the Canadian system. This thesis has implications for TM practice, research and health care policy in Canada. A case has been made for a 'Multicultural health care' policy for Canada. The thesis concludes with seven recommendations for further research.

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PhD in Progress

Motherhood and migration: Arab Muslim women in London, oral storytelling in a health information environment.

The study, which is in its final year, looks at the functions and uses of knowledge about the body in Arab Muslim women's accounts of pregnancy and birth in London based maternity services and relates these understandings to those of motherhood, femininity and Arab Muslim Identity in Diaspora. Exploring modes of transcultural communication in the delivery of maternity services it also focuses on the delivery, perception and reception of information from maternity services maternity information. Finally, considering the perspectives of maternity health professionals on knowledge/information and motherhood, it will relate these to restrictions on information-giving encounters with Arab Muslim women imposed by health professional training and perceptions of government guidelines on equitable access and information provision.

The broad aim of the study is to develop a dual aspect on maternity information provision within the context of Arab Muslim cultures and beliefs in London and those of maternity health professionals. Reconstructed stories were used to prompt accounts from Arab Muslim women with the same method, having been used to validate the findings among both groups and to present findings under themes relating to the functions of information/storytelling and understandings of the body/identity.

The study has developed a perspective on the construction of knowledge and embodied identity across three broad areas:

1 **Meanings of motherhood**
In the case of Arab Muslim women, expressions and references to Pan-Islamic conceptions of 'responsible motherhood' that relate closely to beliefs regarding personal agency and control as well as classed (peasant) beliefs regarding feminine resilience are discussed together with references to meanings specific to national groups.

2 **Constitution and Functions of Knowledge about the body**
Considering ways in which the body is imagined by women and health professionals, issues of agency and control of bodily processes through information emerge and contrast strongly with embodied understandings of the self subject to physiological change that appear in storytelling accounts. Understandings of bodily openness and the loss of a sepa rate self in pain also appear to relate to this binary with narrative accounts enabling women to imaginatively project themselves through the experience of labour pain, while health professional information particularly in its visual form appears highly distrusted by this group of Arab Muslim participants for its presentation of a static experience of pain. In contrast for more urban and educated women, storytelling is strongly critiqued for its descriptions of labour pain that appears to be perceived as diminishing the status of motherhood. For health professionals storytelling appears to be distrusted by a majority who consider it as a medium to present cultural sanctions against interventions. In these cases information by health professionals is perceived as enabling maternal choice in a non-cultural context.

3 **The cultured maternity information environment**
The third focus of the study relates to the extent to which the information-giving encounter between women and health professionals can be considered as cultured and considers how this environment may interact with Arab Muslim cultures and those of health professionals given perceptions of the individual and information/knowledge among both groups.

Myfanwy Davies,
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AGONY AUNT

Dear Marge,

I have received several presents from students on my course for Christmas and New Year. What am I to do? Should I refuse these in order to keep clean in the eyes of the Nolan Committee and upset or offend these (overseas) students? Or can I accept presents such as these without getting into trouble?

Embarrassed Lecturer from Rotherham

Reply from Marge

Dear Embarrassed from Rotherham,

The Nolan Committee's First Report on Standards in Public Life identifies the so-called **Seven Principles of Public Life.**[1] These principles apply to all aspects of public life. The Committee has set them out here for the benefit of all who serve the public in any way. Of these seven principles-selflessness; integrity; objectivity; accountability; openness; honesty and leadership-integrity is perhaps the most relevant to your question. Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might influence them in the performance of their official duties. At the same time you must be culturally sensitive; in some cultures students are expected to give presents to academics, sometimes these presents come from the students' parents for helping and guiding their offspring. On balance I feel you can accept these unsolicited and unexpected gifts. Just make sure that these presents are clearly a token of appreciation, and are seen as such by both the student and yourself. The only problem I can see is jealous colleagues, but that's not your problem.

Reference:

1. Nolan Committee (1995) First Report of the Committee on Standards in Public Life [Cm 2850-I], London: The Stationary Office. Web address:
http://www.archive.official-documents.co.uk/document/cm28/2850/2850.htm

Reply from Marge's Friend Fran

Dear Embarrassed from Rotherham,

Don't be. Just be glad that someone appreciates your work. I'm sure you are otherwise underpaid and overworked and generally unappreciated by your institution.

Dear Marge,

Reflecting on last issue's letter from Boxed In, I have started to wonder about facilities provided to us medical sociologists working in University environments in a wider sense. The issue of particular concern to me and a number of my colleagues at the moment, is the lack of social amenities available to us on campus. Not only have we no staff common room, but two of our treasured social venues (a senior common room and a visitor's centre) have recently been closed. We are left with a poor substitute (a few chairs dumped in the middle of a hall in one of our student residence buildings) and feel that the quality of our working day is drastically depleted by this loss of social outlet. Do you think this is part of a conspiracy to ensure an individualised, goal-oriented work force? And if I want to do anything about this erosion of anything pertaining to a stimulating social/academic environment on my university campus, where am I to turn?

Yours feeling begrudged and isolated,
Medical Sociologist at anti-social university

Dear Marge,

Further to my previous communication about my appalling working conditions and referring to 'boxed in's' situation, we have just been instructed to clear the clutter from under our desks - bang goes another loophole in the Departmental rules and regulations. The thing is, my desk serves as the recycling centre for the Department as we currently have no recycling facilities for anything! I recycle paper and printer cartridges and any rubbish that I think I can make use of. No wonder I have to move to a bigger flat.

However I do have an empty desk opposite me, so will have to expand my clutter into it. I don't think there are rules about that yet, as the BELOW DESK CLEAR POLICY is for health and safety reasons. If no-one sits at a desk there cannot be any risks to health and safety, can there? In fact there are two other empty desks not far from me, so I could even spread it all out. I think I could have a regular column in MSN. There are always ways and means.

Still belligerent sociologist

Dear Marge,

I am a PhD student doing research on families. I sent questionnaires to mothers and invited them to comment on their experiences and decision making. Typing up the hand-written comments, I find there are some spelling and grammatical errors which can be hilarious. One woman, for example, had her children by 'donner' insemination. Another wrote, 'my waters started leeking'.

My problem is, do I correct these mistakes before presenting them to the public, or do I leave them as they are? If the latter, do I put 'sic' to show it is their mistake and not mine? I feel that 'sic' after an error sounds awfully superior, like I can speak better english than what (sic) they can. My supervisor does not seem to know what I should do. Can you help Marge?

Yours very sincerely,
Prematurely grey PhD student

Reply from Marge

Dear Prematurely Grey,
Sorry but I can't help you because I am taking industrial action. I suggest that you do the same.

Yours Marge

Reply from Marge's Friend Fran

Dear Prematurely grey PhD student

If you transcribe the text of an interview or focus group verbatim, you won't change any of the grammatical errors or mistakes in word order or tense which your interviewees or focus group participants have made. Following this logic, I would not attempt to improve the English of the comments made by your research participants. In your Methods Section, or at the start of your Results section, inform the reader that you are aware of spelling and stylistic errors in some of the comments, but that you have decided, in the interests of authenticity, to keep the original language. This will also provide the reader with greater insight into the study participants' experiences and their verbalisations of them.

BOOK REVIEWS

Costello J, M Haggart (eds) (2003) Public Health and Society. Basingstoke: Macmillan. [ISBN 0333971736 Pbk £16.99]

This text sets out to be accessible for student nurses and other practitioners in Community Health settings, providing an overview of health needs and service provision. The book's format is certainly very clear, and each chapter is introduced by way of bullet points and is likewise neatly summed up. Without being patronising one also feels that knowledge is not assumed thus definitions of basic terms are often incorporated and each chapter also includes relevant texts for further reading.

Part one is a strong section beginning with Joel Richman's succinct yet thorough history of public health. I liked the way that Richman provided definitions of terms such as globalisation, assimilation and multiculturalism. My only concern when reading this chapter was the point where he seems to be presenting the Lunacy Act (1891) as an improvement in public health even though he points out that it 'classified the mentally impaired into lunatics, imbeciles, and idiots; their differing degree of pollution/danger related to their spatial separation'. In general, though it really lays the foundations for background knowledge in public health.

Ron Iphofen's essay introduces food for thought highlighting how it is too simplistic to assume that one can rely purely on socio-economic factors arguing that we need to explore further into patients' perceptions of their own health - this to me seems primarily a focus on qualitative data. Essentially he points to mediating factors: 'There is some suggestion that sensed relative deprivation within social hierarchies has more of an effect on health outcomes.' By way of illustration he points to the fact that those with extreme physical or learning difficulties have low levels of sensed injustice about restricted opportunities. The bottom line here is the problem of individuals gaining access to their own feelings of need.

Brocklehurst and Costello's article is centred on the Black Report (1980). This report acted as a watershed text to draw attention to the link between social inequalities and health. It deals with social factors - a combination of social change and medical innovation - from Victorian times up to the report and then goes on to show how the gap has widened even further subsequent to the report.

Part II looks at public health and control. It opens with Costello, Richman and Wong providing an absorbing discussion on one particular ethnic minority that of Chinese communities in Manchester. It explores this particular community to show the lack of understanding and respect that can be given to some ethnic health practices. It takes the example of 'coining' - the treatment of fevers by placing of coins of the child's forehead, showing how this was often misinterpreted as abuse. Ultimately the chapter argues against the dangers of globalisation.

Maryam Spanswick focuses on how powerful institutions influence individual vulnerability and perpetuate the process of marginalisation. This chapter tends to be rather long-winded in places spending too much time focussing on definitions of vulnerability. At times it leaves the reader to do too much work particularly where it rather bizarrely suddenly slips a discussion of vulnerability and murder into the discussion with no clear introduction.

Martin King finishes off Part II with an entertaining exploration of media constructions of health. He argues, for example, that the way we look at public health is as much (if not more) a product

of the media as of the medical profession. King then goes on to show how media-based health promotion has changed over the years, and how these changes often reflect the political agenda as much as the health agenda of the time. He concludes by arguing that the media-based health promotion still has its place, but only by learning from the past and, for example, resolving the differences between political and health professional concepts of public health.

The final part of the book focuses on the professionalisation of public health. It opens with Maria Horne looking at the health needs of communities and populations. In particular she looks at the role of, and problems with, needs assessment, covering issues such as the problem of "a dominant 'world view' of health" (p.130), and political influences. John Costello then looks at social exclusion in relation to public health. He first defines what social exclusion is, then looks at who is excluded and why. Costello then considers the Government response to this situation, arguing that initiatives such as social exclusion units and developing community-based partnership may well succeed where previous 'top-down' approaches have failed.

Monica Haggart concludes the book by pulling together the themes of the previous chapters and discussing them from the perspective of the profession, identifying structural issues that prevent the health service from functioning effectively. Haggart suggests that the solution to the problem is professionals, in particular public health nurses, working as advocates for their local community.

Overall, this is a highly readable book, and useful for any student studying public health from a social perspective.

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McNamara, B (2001) Fragile Lives: Death, Dying and Care. Maidenhead: Open University Press. [ISBN: 0335208991 Pbk £18.99]

Beverley McNamara's book offers a predominantly sociological interpretation of stories of people close to death and their carers. Through the use of social patterns, McNamara highlights connections between individuals facing 'certain' death and society - with society being made up of individuals contemplating death in the more distant future. Clearly, this connection is the knowledge that everyone will die and it is this philosophical dimension that makes the accounts of people close to death more poignant. McNamara argues that beneath the surface in western society, there are tensions that arise from different constructions of death. She traces these tensions through to a key current dichotomy between technical rationality and uncertainty.

Fragile Lives begins with a review of the sociological literature which contextualises contemporary views of death and dying. McNamara claims that only by making sense of death can people face the possibility of their own death. In the second chapter McNamara examines the way that dying people talk about death and supports Giddens' argument that by 'neglecting death' people are able to function effectively in 'life'. She extends this to acknowledge that only when people face their own dying are they in a position to make accurate statements about their personal and ethical view of issues such as euthanasia.

In Chapter 3 she considers how people make sense of cancer. More recent technological innovations and life-prolonging treatments mean that the illness trajectory for people with cancer has become increasingly uncertain. McNamara argues this uncertainty and the iatrogenic symptoms from cancer treatments, sets it apart from other disease trajectories. The next chapter focuses on the notion of a 'good death' within the hospice. McNamara argues that the problems associated with the prescriptive nature of a 'good death' are not all overcome by the 'good enough death' concept. Indeed this compromise, she argues, does not allow for individual diversity, but rather, is more likely to result in the institution handing over full responsibility to the individual dying person. In her own words, ' the good enough death may be so loosely constructed that it lacks shared meaning.' (Page 52).

Chapter 5 is more focused on personal experiences of dying and considers the relationship between the dying body and the personal and social worlds of the dying person. I was dismayed that there was no reference to Julia Lawton's (2000) ethnographic account of the relationship between the self and the body during terminal illness. In Chapter 6 there seemed to be so many links between the medicalisation of death and cancer deaths that I thought this could have been incorporated into the cancer story in the earlier chapter. I would have welcomed, too, more discussion of the medicalisation of palliative care. Clearly linked to these issues are the debates around disclosure and this is the subject of the next chapter. The discussion of some of the ethical and philosophical dilemmas that result from the privileging of individualism in western society was well focused in chapter 8 through patient autonomy and professional control.

The focus then shifts from the experience of dying to the rewards and costs of caring. McNamara uses an 'out of place' sudden death in a hospice to examine the shared values that structure the coping system for hospice staff. It would have been interesting to connect the ideas here to the 'good death' debates raised earlier. The final chapter questions the role of the hospice movement and the apparent compromise of its original vision. These debates are well rehearsed in the academic literature and include moral, political and medical dimensions. McNamara concludes that even within palliative care, the emphasis has shifted away from 'dying well' to 'living well'. It would seem that dying people are not excluded from acting out the current 'western' way of death.

I would recommend this book to anyone with a sociological interest in death and dying. It is thought provoking and well illustrated by personal stories from dying people. I think that there is a slight tension between the analysis here and McNamara's declaration in the preface that death should be managed in a 'sensitive and socially responsible manner'. Is there a dilemma for all researchers who examine death and dying and its constructions in society and the place of their personal constructions within the analysis? Perhaps, the nature of analysing prescriptions for types of death could have been more reflexively articulated as part of the analysis. Finally, it seems that the relationship between the reader of the accounts in this book mirrors the sense that 'living' people in society need to make of 'dying'. Those searching for a sociological meaning will find this a helpful guide.

Reference: Lawton, J. (2000) The dying process. London: Routledge.

Carol Komaromy
Open University

Hughes D, Light D (eds) (2002) Rationing: Constructed Realities, Professional Practices. Oxford, Blackwell. [ISBN 0-631-22857-9-8 Pbk £15.99]

This important collection of papers was first published as a special issue of *Sociology of Health and Illness* in 1999. The editors remind readers that health care rationing is a crucial issue in health policy yet, surprisingly, has been largely ignored by sociologists. The reason for this relative neglect of rationing by sociologists is a bit difficult to explain. One consequence has been that the field is dominated by economists and by overly rational models of decision-making. So this collection is to be welcomed on several counts. At last we have a collection of empirical papers that begins the process of opening up clinical decision-making and the rhetoric and practices around rationing, to specifically sociological analysis. The papers include work from the USA, Canada, France as well as the UK. What unites these different locations is the common tension between traditional conceptions of medical autonomy, with its emphasis on individualised and particularistic ways of making decisions, with systems (and rhetoric) that emphasise a 'system of utilisation review that was designed to embody the highest standards of scientific rationality' (172).

The book opens with the editors claiming, 'The analytic power of sociology stems from examining closely the deep structures and power relations that underlie the rhetorics and practices of individuals, groups and organisations, by assuming a radical disengagement from them' (p1). Hear hear. This should remind us that disengagement is as important as involvement in the attempt to 'understand' actors and their social situation. Too much contemporary sociological research is blighted by this attempt to capture the experience of groups through immersion and involvement. Lets have a health warning about too much empathy!

The editors claim that not only is the topic of immediate policy concern, it provides a 'valuable array of social practices for exploring power relations in health care systems, particularly the linkage between resource allocation, rhetoric and the interests of different parties' (p1). Several contributors make the point that crude economic conceptions of rationing create a blunt dichotomy between decisions to treat or deny treatment. Empirical work in a range of settings reveals this to be oversimplified. Staff also exert discretion and sometimes in unexpected ways. Carine Vassy reports in her chapter on categorisation and micro-rationing in a French emergency department that, 'staff tended to follow an informal rule according to which they accepted persons with social problems...whatever the clinical seriousness of their condition'. This challenges well-known previous research which describes professional typifications of 'normal' and 'rubbish patients'. She argues that the staff she studied 'had set up an informal system of positive discrimination' (p78).

The book is full of fascinating insights into the working world of doctors, nurses and managers. A much-repeated assertion is that rationing has moved from being a covert activity to one that is now open to scrutiny and greater transparency. On some of the evidence presented here we should treat such a claim with caution. There are eight chapters organised around four main themes - risk and rationing, rationing in hospitals, rationing in the community and professional resistance to rationing. Some of the chapters also subject the rhetoric and practices around rationing to specifically sociological analysis. One consequence of the neglect by sociologists has been that the field is dominated by economists and overly rational models of decision-making. For the readership of Medical Sociology News there is little need to stress this point, but case study material of the type offered in this collection is just what is needed - detailed, rich and revealing how economic transactions are embedded in social relations.

There is an excellent chapter by Albrecht on rationing health care to disabled people. While Lapsley and Melia, in their chapter on rationing intensive care, make a useful distinction between 'hard' and 'soft' rationing. The former exists where the limits on action are tightly drawn because of the existence of non-negotiable physical or financial limits on action and the latter when there is greater leeway for the 'actions of key actors within the organisation' (p189).
The editors do not set out a research agenda but they suggest that future work is 'best set within a wider sociology of resource allocation, which can draw on work from economic sociology, organisation studies, and the sociology of health and illness to take back some of the territory that for too long has been conceded to other disciplines' (p17). Now that is the kind of challenge likely to stir up the readership of MSN.

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Brannen J, Moss P (eds) 2003 Rethinking Children's Care Buckingham: Open University Press. [ISBN 0 335 20987 4 Pbk £17.99]

The contributors to this book are all researchers at the Thomas Coram Research Unit in the University of London, named after the eighteenth century pioneer in the care of foundling children. It is underpinned therefore by one of the characteristics of the unit, its willingness to question social policy and practice. The book also has a strong historical element, showing how ideas about care, its language and practices, are produced and reproduced. Contributions to the book centre around three issues: developments in the conceptualisation of care, the relational and power aspects of care, and developments in care as social policy. Issues of power and control surface in many of the chapters, and as the editors observe, taking a Foucauldian view of power as local and diffuse, services for children are an important site for the exercise and study of power relations, in which the discourses of professionals and experts are highly influential in the shaping of identities.

The authors of this book view children as active in care relationships and givers of care, rather than as passive dependents. Children as a social group occupy a number of social statuses, and adults also occupy the generalised status of children, as the offspring of parents. The book therefore takes a broad view covering a wide range of settings and carers, which raises the question of the extent to which care is a meaningful concept when used so widely.

As the editors observe, policy relating to care, and the associated discourses and practices, may not be subject to much conceptualisation by policy makers, and British social policy lacks a conceptual language to link citizenship and interdependence. Policies are shaped by powerful, often unexamined discourses, particularly, in children's care, in relation to gender and the degree to which women are assumed to be financially dependent on men. The editors argue that Britain has recently seen the development of advanced liberalism, in which autonomous individuals accept responsibility for managing their own risks and those of their family, achieving autonomy through paid work. Children's care is therefore seen as a private concern, the exception being care for children in need.

Chapters 2 to 5 examine how care has been conceptualised over time, and how these concepts have been translated into practice. Chapters 6 to 9 focus on care in formal settings (nurseries, social services, childminders and nursing). Chapters 10 and 11 look at informal care within families, and chapter 12 concludes with a brief discussion of implications for policy. Particular highlights for me are Christine Oliver's chapter (chapter 3) based on interviews with elderly people on the rigours of life as Coram pupils. They were protected from the widespread poverty of the early twentieth century, but largely lacked emotional care. Most left the Foundling Hospital at 14, as abruptly as they had joined it, and then had to negotiate the secrets and silence surrounding illegitimacy, which acted as a barrier to the transmission of knowledge across the generations. Many set down their memories for their own children, so that they would not themselves feel rootless.

Claire Cameron (chapter 5) provides an historical perspective on changing child care policy, by examining four pieces of legislation, the 1872 Infant Life Protection Act and the 1908, 1948 and 1989 Children Acts. Over the time period examined, the scope of the term 'care' has widened from the basics of food and shelter, to include at least some notion of partnership. Since the 1989 Act, the provision of care has become further distanced from the state and the public image of social care and social work has deteriorated. Despite a renewed emphasis on family support, lack of investment has subsequently contributed to a narrowing of the definition of care and a lowering of expectations about what the state can offer. As a result, public care is becoming more stigmatising.

Helen Chalmers and Peter Aggleton (chapter 9) aim to examine the role of health care, particularly children's nursing, in the promotion of children's health (although the term health promotion is used rather loosely, since the focus is on acute care). They suggest a rights based approach, based on the UN Convention on the Rights of the Child. I admit that I was disappointed by this chapter, much of which is based on a rather uncritical use of nursing models.

Like most edited volumes there is a risk of variations in quality and a lack of coherence, although generally this is overcome by the editors. Themes identified in the conclusion include the blurring of boundaries between care services and other services, particularly the boundary between care and education, and between formal and informal care, the repositioning of mothers as workers and new patterns of employment in the service sector. The question of who will care in the future is also briefly discussed. However, the theme of reconceptualising children as active interdependent citizens was not developed in the book as strongly as I had anticipated. The view of childhood is essentially benign, and does not include the theme of anxiety about, and demonisation of, children, as explored by Marina Warner and others. The editors also argue for a greater attention to ethics and to care as a political concept. To create the space for reflection, we would need to move away from the emphasis on outcomes and targets which are such a feature of the current administration.

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Armstrong, D (2003) Outline of Sociology as applied to Medicine (Fifth edition) London: Arnold. [ISBN 0-340-80920-5 Pbk £16.99]

This 'classic' sociology textbook for medical students is now in its fifth edition. The new edition consists of fourteen short and concise chapters, ranging from 'Coping with illness' to 'Social causes of illness' and from 'Models of illness' to 'Evaluating health care'. The overall structure runs from the individual (e.g. illness behaviour, and going to the doctor) to the social (e.g. the organisation of health care and the social role of medicine). Each chapter is clearly divided with relevant sub-headings. The book fits in well with the General Medical Council's (GMC) recommendations on undergraduate medical education in Tomorrow's Doctors, for example, under the GMC's headings of 'The health of the public' and 'The individual in society'.

The curricula in UK medical schools have incorporated more social and behavioural science perspectives, in some cases in a very integrated and/or problem-based learning approach. This has boosted medical sociology, health psychology, medical anthropology and health economics in medical schools. However, the downside is often that individual academic disciplines get lost in an integrated curriculum. There is a blurring of boundaries. My experience is that there is a tendency towards an integrated medicine course, where disciplines are less important, but there is an integration of academic subjects in multidisciplinary teaching. Under this scenario the actual discipline that introduces the notion or concept of, for example, the Sick Role, 'Quality Adjusted Life Years (QALYs)', or 'Help seeking behaviour', becomes less important. Something to this effect can also been seen in this textbook, as aspects of it belong more to 'social epidemiology' or 'health economics' or 'health services research' rather than 'sociology'. For example pages 127-128 have a lot of health economics concepts, such as 'cost minimization analysis', 'cost-benefit analysis' or 'cost utility analysis' and little sociology. It even says in the text on page 129 "This is an economist's way of saying that years of life in the future are worth less than years of life now." For medical students this is a nice example of an integrated approach, however, some sociologists (and health economists) perhaps do not expect such health economics material in a book with the title Outline of Sociology as applied to Medicine.

Medical students will love the applied side of the book. For example, Chapter 9 uses one common patient complaint, namely 'abdominal pain' as an example to illustrate 'models of illness'. The chapter continues with a discussion of models of the doctor-patient relationships. Textbooks seem to have more and more illustrations these days, but Armstrong's book is an exception to this trend. The book has few illustrations, on average about two or three tables or diagrams per chapter. Having said that, I think that is enough illustration for most chapters.

The book is up-to-date on issues such as 'clinical governance' (p.112) and reasonably so on 'The future of health care' (123-124), although the latter section has perhaps a little too much detail on the internal market, which is now out of fashion, at least in the UK.

I would recommend this book as a course book for medical students in the first two or three years of their degree. I am sure that lecturers teaching social sciences on nursing, midwifery, health visiting and related degrees will also find this a good introduction to sociology for their students.

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Summerton J, Berner B (eds) 2002 Constructing Risk and Safety in Technological Practice. London: Routledge [ISBN 0415285712 Hbk £60]

This is an edited work, based on papers given at a workshop on "Social Construction of Risk and Safety" which took place in Sweden in 2000. It consists largely of case studies, which seek to show "how risks are interpreted, handled and debated by groups of actors in their everyday practice". The case studies are drawn from a wide variety of areas, including air traffic control, air crash inquiries, nuclear power and the automotive industry.

The theoretical approach of the book is interesting in that it seeks to draw together perspectives from psychology, cultural studies of risk, and sociology. In the case of sociology it certainly goes some way towards addressing the criticism made of , for instance, Beck, that the current interest by sociologists in issues of risk has not lead to much in the way of empirical work. However, though the editors have tried in the introduction to bring these perspectives together, the individual case studies are very much in their own traditions, which means that they sometimes do not illuminate each other as much as they might.

Nevertheless, the book has much that is useful and interesting to say. One highlight is the chapter on "bunkering" at the Los Alamos Plutonium Handling Facility. This shows how the staff within the facility developed very different ideas and constructions of risk from people they perceived as outsiders, and that this 'bunker' mentality leads to only very guarded communication with the outside world, even on issues that may not, of themselves, be sensitive. Staff effectively remove themselves from any sort of interaction with the outside world about the safety (or otherwise) of this plant. I think that this concept of 'bunkering' could fruitfully be applied to the attitudes of health care staff, especially around issues like catastrophic errors in care.

Perhaps of most interest to readers of MSN is the chapter on the construction of safety in the face of fear and distrust in a cardiac intensive care unit (ICU). This is based on observations and interviews conducted on an ICU in Sweden. What the author shows is that safety is not just about interactions between patients, staff, and the high-tech devices in the unit, but also, crucially, constructed through staff interactions with each other. Drawing on ideas from Goffman, she demonstrates how it is permissible for staff (in this case nurses) to show fear, but only in certain ways, and that they must legitimise that fear in order for it to be accepted by other staff. Someone who transgresses these informal rules runs the risk of being labelled an unsafe practitioner by their colleagues. The nurses interviewed also had to manage the enduring issue of how to influence those (principally doctors) who had higher status than they did, and this study makes a useful contribution to our understanding of this issue.

Though this book suffers from the usual problems inherent in this type of volume, in that it is sometimes difficult to see how case studies done for very different reasons from different perspectives can be drawn together, there is enough in here to make it worthy of recommendation to readers who are interested in issues of risk, and specifically the social construction of risk, in a health care environment.

Stephen Timmons
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